

OVERSIGHT OF CUSTOMER SERVICE AT THE OFFICE OF WORKERS' COMPENSATION PROGRAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT MANAGEMENT,
INFORMATION, AND TECHNOLOGY

OF THE

COMMITTEE ON
GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

MAY 18, 1999

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OVERSIGHT OF CUSTOMER SERVICE AT THE OFFICE OF WORKERS' COMPENSATION PRO- GRAMS

TUESDAY, MAY 18, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON GOVERNMENT MANAGEMENT,
INFORMATION, AND TECHNOLOGY,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2154, Rayburn House Office Building, Hon. Stephen Horn (chairman of the subcommittee) presiding.

Present: Representatives Horn and Biggert.

Staff present: J. Russell George, staff director and chief counsel; Matthew Ebert, policy advisor; Bonnie Heald, director of communications/professional staff member; Mason Alinger, clerk; Faith Weiss, minority counsel; and Earley Green, minority staff assistant.

Mr. HORN. The Subcommittee on Government Management, Information, and Technology will come to order. We are here today to learn how well the Office of Workers' Compensation Programs at the Department of Labor is treating Federal workers who are injured on the job.

The Federal Employees Compensation Act authorizes Federal agencies to compensate Federal employees when their injuries are sustained on the job. The act was intended to develop a nonadversarial arrangement whereby Federal employees would be compensated in a fair and equitable way while reducing the Federal Government's exposure to tort liability.

Concerned by allegations that the process is unfair and structurally flawed, the subcommittee held a hearing in Long Beach, CA, on July 6 of last year to evaluate and discuss these issues. The complaints involved delays in medical authorizations, payments for medical treatment and the lack of judicial recourse. Some of these delays were so serious that one injured worker testified that the waiting period left him financially devastated and nearly cost him his life.

What was especially evident in all of the testimony were concerns with the customer service issues at the Office of Workers' Compensation Programs [OWCP]. It was alleged that it is very difficult for a claimant to make contact with the office and that the response rate is very poor. Testimony suggested that when a claims examiner has been reached, the Federal worker receives little or no

guidance. It has been suggested time and time again that Federal workers have to turn to lawyers, unions, and congressional offices to assist them in getting a simple response.

Union members, congressional offices, lawyers and individuals who are entrenched in the claims process continue to contact the subcommittee about their negative experiences with the Office of Workers' Compensation Programs, the agency responsible for administering claims for injured workers. Some of these people will not be able to testify today, but will submit statements for the record.

Senator Slade Gorton of Washington has expressed his frustration in assisting constituents who are struggling with their workers' compensation claims.

Mr. Gorton will be submitting a statement for the record, as will Mr. John D. McLellan, Jr., a former Director of the Federal Employees' Compensation Programs, a division of the Office of Workers' Compensation Programs. After retiring in 1985, Mr. McClellan, a lawyer, attempted for 8 years to assist Federal injured workers through the FECA appeals process. His testimony is especially revealing, because of his close contacts with the OWCP and frustrations in attempting to guide Federal injured workers through the process. Mr. McClellan's statement will also be submitted for the record.

Today, the subcommittee will examine whether the Office of Workers' Compensation Programs is performing its mission of administering the Federal Employees' Compensation Act in a fair, timely, and efficient manner. The subcommittee will also examine how well the agency is doing in developing top-of-the-line customer service. In addition, we will examine the effectiveness and accuracy of the agency's customer service survey.

The first panel will include former Federal employees who have been injured on the job. These witnesses will describe the nature of their experiences throughout the claims process and the obstacles they have confronted.

The second panel of witnesses consists of professionals who have dealt with the Office of Workers' Compensation Programs while treating, representing or assisting Federal injured workers through the appeals process. These witnesses represent a medical clinic, a Federal union, a law firm and a congressional office.

Panel III will include representatives of the Office of Workers' Compensation Programs, who will discuss improvements in customer service at the agency, and a representative of the Office of Inspector General of the Department of Labor, who will discuss its recommendations for improving the medical authorization process and the agency's customer service survey.

I welcome our witnesses today, and I look forward to their testimony.

[The prepared statements of Hon. Stephen Horn and Hon. Jim Turner follow:]

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INDEPENDENT

**"Oversight of Customer Service at the
Office of Workers' Compensation Programs"**
Statement by Congressman Stephen Horn (R-CA)
**Chairman, Subcommittee on Government Management,
Information, and Technology**

May 18, 1999

A quorum being present, the Subcommittee on Government Management, Information, and Technology will come to order. We are here today to learn how well the Office of Workers' Compensation Programs at the Department of Labor is treating Federal workers who are injured on the job.

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Concerned by allegations that the process is unfair and structurally flawed, the subcommittee held a hearing in Long Beach, California on July 6th of last year to evaluate and discuss these issues. The complaints involved delays in medical authorizations, payments for medical treatment and the lack of judicial recourse. Some of these delays were so serious that one injured worker testified that the waiting period left him financially devastated and nearly cost him his life.

What was especially evident in all of the testimony were concerns with the customer service issues at the Office of Workers' Compensation (OWCP). It was alleged that it is very difficult for a claimant to make contact with the office and that the response rate is poor. Testimony suggested that when a claims examiner has been reached, the Federal worker receives little or no guidance. It has been suggested time and time again that Federal workers have to turn to lawyers, unions, and congressional offices to assist them in getting a simple response.

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Mr. Gorton will be submitting a statement for the record, as will Mr. John D. McLellan Jr., a former director of the Federal Employees' Compensation Program, a division of the Office of Workers' Compensation

Program. After retiring in 1985, Mr. McLellan, a lawyer-attempted for eight years to assist Federal injured workers through the FECA appeals process. His testimony is especially revealing, because of his close contacts with the OWCP and frustrations in attempting to guide Federal injured workers through the process. Mr. McLellan's statement will also be submitted for the record.

Today, the subcommittee will examine whether the Office of Workers' Compensation Program is performing its mission of administering the Federal Employees' Compensation Act in a fair, timely, and efficient manner. The subcommittee will also examine how well the agency is doing in developing top-of-the-line customer service. In addition, we will examine the effectiveness and accuracy of the agency's customer service survey.

The first Panel will include former Federal employees who have been injured on the job. These witnesses will describe the nature of their experiences throughout the claims process, and the obstacles they have confronted.

The second panel of witnesses consists of professionals who have dealt with the Office of Workers' Compensation Program while treating, representing, or assisting Federal injured workers through the appeals process. These witnesses represent a medical clinic, a Federal union, a law firm, and a Congressional Office.

Panel three will include representatives of the Office of Workers' Compensation Programs who will discuss improvements in customer service at the agency, and a representative of the Office of Inspector General of the Department of Labor who will discuss its recommendations for improving the medical-authorization process and the agency's customer service survey.

I welcome our witnesses today, and look forward to their testimony.

Statement of the Honorable Jim Turner
GMIT: "Oversight of Customer Service
at the Office of Workers' Compensation Programs"
May 17, 1999

I would like to thank Chairman Horn for holding this hearing. Today, we will look at the customer service aspect of the Office of Workers' Compensation Programs. While we will be provided with some of the details of one good experience with the agency, we will focus primarily on problem areas. It is important that we hear from those who are having difficulty with any federal program, especially those who have been injured in the course of their federal employment and are in need of care and treatment.

The Office of Workers' Compensation Programs administers the federal workers' compensation program, which was created by the Federal Employees' Compensation Act (FECA). The FECA passed in 1916 to assure that injured federal workers receive appropriate medical treatment and benefits. Since that time, the goal of the program has been to provide those who are injured with the resources to return to their jobs and fair compensation for those who cannot.

Today, we will hear from one federal employee who will soon return to work about his experience with the program. I would like to welcome a fellow Texan, Special Agent Matthew Fairbanks, who is in Washington D.C. to receive the highest honor his agency can bestow for the bravery he exhibited during a helicopter crash that tragically took the life of his instructor. While here in D.C., he also will attend an award ceremony recognizing the superior efforts of his nurse, Sue Maraglino, who oversaw his rehabilitation.

I would like to welcome our other witnesses as well. We will also hear from some former federal workers whose experiences with the workers' compensation program have been unsatisfactory. Their complaints are important, because they will help us in our troubleshooting efforts to identify the problems and focus on a solution. These injured federal workers have had difficulty obtaining answers to their questions about their respective cases and have not experienced prompt and courteous treatment. Documentation that they have a right to receive has not been forthcoming, and in at least one situation, requested medical records, which clearly should remain confidential, were sent to the wrong person.

Many of the complaints that we will hear about today appear to be more common than they should be for individuals contacting the workers' compensation program. This is inexcusable, and there should be measures within the program to assure that all of its staff are as competent, courteous, and professional as Nurse Maraglino.

The Office of Workers' Compensation Programs has solicited the opinions of injured federal workers on customer services, and only 56% of those surveyed indicated satisfaction with their treatment—revealing that there is room for substantial improvement at this agency. The agency collects some information on customer service, but, as the Inspector General notes, it may not use this information effectively. If resource constraints are causing these customer service problems, I would hope that the agency is looking creatively at ways to maximize their resources and to find the money to ensure better service.

This hearing will provide us with an understanding of some of the most prevalent concerns regarding customer service at the Office of Workers' Compensation Program. My hope is that this hearing can help the agency focus on the areas that need the most improvement. The Office of Workers' Compensation Programs should develop targeted responses to these customer service complaints and track their progress.

Mr. HORN. Let me explain how we will go about this. Since this is an investigating subcommittee of the Committee on Government Reform, all of our witnesses are sworn prior to their testimony, and we will begin with panel I this morning. I see they are in their chairs.

Mr. Thomas Chamberlin, former agent of the Federal Bureau of Investigation. Welcome, Mr. Chamberlin. Dianne McGuinness, former employee of the Social Security Administration. Welcome. And Matthew Fairbanks, special agent/pilot, Drug Enforcement Agency. We welcome you also.

So if you will stand and raise your right hands.

[Witnesses affirmed.]

Mr. HORN. The clerk will note all three witnesses affirmed.

We will begin with this panel; and if we have time before 12:15, we will begin with part of panel II, Beth Balen in particular. She has come the longest distance, namely Anchorage, AK; and we want to accommodate her. We will try to go all through panel I and begin panel II, and at 12:15 we will take a break until 2 p.m., when the hearing will pick up again.

So, Mr. Chamberlin, why don't you tell us in your own words, because we have all read the documents, which are very detailed and very helpful to us, but summarize for us, if you would, because we would like to enter into a dialog on this in terms of questions and answers. So don't feel you have to read everything.

We are going to give you at least 10 minutes here to get through your statement; and then we will go to the next person, Ms. McGuinness, Mr. Fairbanks; and then we will have questions.

So please proceed.

STATEMENTS OF THOMAS CHAMBERLIN, FORMER AGENT OF FEDERAL BUREAU OF INVESTIGATION; DIANNE MCGUINNES, FORMER EMPLOYEE OF SOCIAL SECURITY ADMINISTRATION; AND MATTHEW FAIRBANKS, SPECIAL AGENT/PILOT, DRUG ENFORCEMENT AGENCY

Mr. CHAMBERLIN. Mr. Chairman and distinguished members of the subcommittee, thank you for providing me the opportunity to present the barriers I have encountered in the process of filing a workers' compensation claim with the Office of Workers' Compensation Programs with the intent to provide a synopsis of DOL-OWCP's action for analysis to improve effectiveness and efficiency.

Mr. Chairman, I previously submitted a statement for the hearing today. Therefore, I will briefly summarize the barriers I have encountered.

I had approximately 25 years of Federal service when I filed my claim. I had proudly served with the United States Marine Corps in Vietnam. Following that, I had a brief construction service, and then I began my law enforcement career with the Washington, DC, police, metropolitan DC. Then I followed over as a special agent with the Drug Enforcement Agency, and I concluded my career as a special agent with the Federal Bureau of Investigation.

In 1993, after having been identified as a whistle-blower for reporting improper Title III wiretap matters, the FBI targeted me for a character assassination. This is where the problems erupted. Subsequently, I was removed from the rolls of the FBI in 1994.

On October 17, 1995, I filed a claim at the Department of Labor's Office of Workers' Compensation Programs, a claim which has yet to be finalized. The three barriers I encountered are incompetency, inaction and an adversarial position. The exhibits I will present will overlap in these three areas.

I encountered these barriers first during the initial filings of my claim. In summary, it took 10 months, six mailings, unlimited calls, and action of the Secretary of Labor to initiate the filing of the claim.

The first exhibit I present is from Chris Brandstrip, supervisory claims examiner, Department of Labor; and it is dated April 26th; and it is to the FBI requesting compliance.

Mr. HORN. Without objection, this letter will be put in the record at this point.

[The information referred to follows:]

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Division of Federal Employees' Compensation

April 26, 1996

(904) 232-2821/2

RE: Thomas M. Chamberlin

U.S. Department of Justice
Federal Bureau of Investigation
ATTN: Walter E. Wilson
Supervisory Special Agent
Employee Benefits Unit
Washington, D.C. 20535


Dear Mr. Wilson:

This letter is in response to correspondence received from Mr. Chamberlin concerning his occupational disease claim. As per the Code of Federal Regulations, Title 20 - Employees' Benefits, chapter 10.102 Report of injury by the official superior. "as soon as possible but no later than 10 working days after receipt of written notice of injury from the employee, the official superior shall submit to the Office a written report of every injury or occupational disease... portions of forms CA-1 or CA-2 are provided for this purpose."

We have a copy of claim form CA-2 completed by Mr. Chamberlin and dated on October 18, 1995. As of this date our office has not received his original claim form for due process."

Please investigate why his claim for has not been sent to our office for processing.

Sincerely,


Chris Brandstrup
Supervisory Claims Examiner
Liaison to Department of Justice

✓ CC: Mr. Thomas M. Chamberlin
4310 Old Chapel Hill-Hillsborough Rd
Hillsborough, N.C. 27278

Working for America's Workforce

BARRIER 1-A

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Division of Federal Employees' Compensation
214 N. Hogan Street, Suite 1006
Jacksonville, FL 32202



ATTENTION

OUR OFFICE HAS NO RECORD OF THIS INDIVIDUAL. IT
APPEARS THAT THIS PERSON IS NOT A FEDERAL EMPLOYEE.
WE ONLY HANDLES CLAIMS FOR FEDERAL EMPLOYEES WHO HAVE
SUSTAINED JOB RELATED INJURY OR ILLNESS AND WE CANNOT
HELP YOU WITH THIS MATTER.

WE ARE RETURNING THE MATERIALS YOU HAVE SUBMITTED FOR
YOUR DISPOSITION.

Working for America's Workforce

BARBER 1-6

[illegible]

1. Address Mr. William Is...
 2. Signature (Addressee)
 3. Signature (Addit)
 4. Form 3811, December 1991 U.S. GP

Employment Standards Administration
Office of Workers Compensation Programs
PO Box 37117 Attention: OL-9
Washington DC 20013-7117
Attention: Wm. I. Israel

4b. Service Type ☐ Registered ☐ Insured
☐ Certified ☐ COD
☐ Express Mail ☐ Return Receipt for Merchandise

7. Date of Delivery **SEP 03 1996**

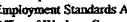
5. Signature (Addressee)

6. Signature (Agent)
Wm. I. Israel

8. Addressee's Address (Only if request and fee is paid)

PS Form 3811, December 1991 GSA GEN. REG. NO. 1962-333-404

DOMESTIC RETURN RECEIPT

3. Article Addressed to: U. S. Dept. of Labor Office of Worker Compensation Administration PO Box 37117 Attention: OL-9 Washington DC 20013-7117 Attention: Wm. I. Israel		4a. Article Number P 303 082 969	
5. Received By: (Print Name) 6. Signature (Addressee or Agent) 		4b. Service Type <input type="checkbox"/> Registered <input type="checkbox"/> Express Mail <input type="checkbox"/> Return Receipt for Merchandise 7. Date of Delivery (Signature of Carrier) SEP 5 1994	
8. Addressee's Address (Only if requested and fee is paid)		9. Certified <input type="checkbox"/> Insured <input type="checkbox"/> CDO	

3. Article Addressed to:
U.S. Dept of Labor
Employment Standards Admin.
Office of Workers' Comp. Program
PO Box 31771 Attn.: OL-9
Washington, DC 20013-7117
Attention: Mr. Wm. Israel

4a. Article Number
P-602-374-819

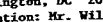
4b. Service Type
☐ Registered ☐ Certified
☐ Express Mail ☐ Insured
☐ Return Receipt for Merchandise ☐ COD

5. Date of Delivery
OCT 21 1996

6. Signature: *William Israel*

7. Addressee's Address (Only if requested and fee is paid)

PS Form 3811, December 1994 Domestic Return Receipt

3. Article Addressed to: US Dept. of Labor Employment Standards Administration Office of Workers' Comp. Program PO Box 37117 Attn.: OL-9 Washington, DC 20013-7117 Attention: Mr. William Israel	4a. Article Number 093 796 140	4b. Service Type <input type="checkbox"/> Registered <input type="checkbox"/> Express Mail <input type="checkbox"/> Return Receipt for Merchandise <input checked="" type="checkbox"/> Certified <input type="checkbox"/> Insured <input type="checkbox"/> COD
5. Received By: (Print Name)	7. Date of Delivery FEB 6 1997	8. Addressee's Address (Only if requested and fee is paid)
6. Signature (Addressee or Agent) 	Domestic Return Receipt	

U. S. Dept of Labor Employment Standards Admin. Office of Workers' Comp Programs PO Box 37117 Attn: OL-9 Washington, DC 20013 Attention: Edward G. Duncan, Assistant Branch Chief	4a. Article Number T 169 690 248 4b. Service Type <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Certified <input type="checkbox"/> Express Mail <input type="checkbox"/> Insured <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> COD 7. Date of Delivery MAR 30 1993
5. Received By: (Print Name) 6. Signature (Addresser's Agent) <i>X [Signature]</i>	8. Addressee's Address (Only if requested and fee is paid)

PS Form 3811, December 1984

BARRIER 2

Memorandum



To: JAMES R. PEREZ
EQUAL EMPLOYMENT OPPORTUNITY OFFICER
Date: 7/19/93

From: SA KAREN Z. MEDERNACH

Subject: THOMAS H. CHAMBERLIN
COMPLAINT OF DISCRIMINATION
FILE NUMBER: F-93-4459-0

Re telephone call from SA MEDERNACH, Milwaukee, to SSA RONALD DAVIS, FBIHQ, on July 15, 1993.

During the course of conducting the captioned investigation, a number of Agents expressed their concern that SA CHAMBERLIN may be emotionally and/or mentally unstable. Several Agents believe he may be a danger to others, as well as to himself. The Agents requested anonymity.

The purpose of this memorandum is to make these concerns a matter of record for the Bureau and the Detroit Division.

280A-HQ-1126339-22

- ① - Mr. PEREZ
- 1 - SAC HELTERHOFF (Personal Attention)
- 1 - SSA RONALD DAVIS
- 1 - Administrative Services Division
Employee Assistance Program

BARRIER 2 + 3

8/7 cgo to Mr. Chamberlain



U.S. Department of Justice

Federal Bureau of Investigation

Washington, D. C. 20535

August 5, 1998

Honorable David Price
Member of Congress
Suite 202
1777 Fordham Blvd.
Chapel Hill, North Carolina 27514

Dear Congressman Price:

Your letter dated July 10, 1998, with enclosures, concerning the Freedom of Information-Privacy Acts (FOIPA) request of your constituent, Mr. Thomas M. Chamberlin, has been referred to me for response.

As a result of another search, we located an additional Medernach to Perez memorandum dated July 19, 1993, which is responsive to Mr. Chamberlin's request. He was furnished an unexcised copy of this memorandum on July 29, 1998.

If I can be of any further assistance to you in this FOIPA matter, please do not hesitate to contact me.

Sincerely yours,

J. Kevin O'Brien, Chief
Freedom of Information-
Privacy Acts Section
Office of Public and
Congressional Affairs

BARRIER 2+3

U.S. Department of Labor

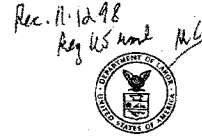
November 5, 1998

Employment Standards Administration
Office of Workers' Compensation Programs
Division of Federal Employees' Compensation
Washington, D.C. 20210

File Number:

Mike Chamberlin
2806 Percussion Drive
Hillsborough NC 27278

File Number: 7004553



Dear Mr. Chamberlin:

We have reviewed your letter of June 2, 1998 with attachments requesting reconsideration of the decision of June 5, 1997.

After a limited review was conducted of this information, it has been determined that this information is not sufficient to warrant review as it is repetitive of information previously submitted or irrelevant in establishing your claim. As noted the attached Memorandum to the Director, it has been determined that the information submitted is insufficient to warrant review the June 5, 1997 decision.

If you disagree with this decision, you have the right to appeal to the Employees' Compensation Appeals Board for review of this decision. A request for review by the Appeals Board should be made within 90 days from the date of this decision. No new evidence may be submitted to the Board. Your request should be addressed to Employees' Compensation Appeals Board, U.S. Department of Labor, 200 Constitution Ave. NW, N-2609, Washington, DC 20210. For good cause the Board may waive failure to file within 90 days if application is made within one year from the date of the decision being appealed.

Sincerely,

Marilyn R. Preuit
Hearing Representative

CC: FBI

BARRIER 3

Mr. HORN. Thank you. Please proceed.

Mr. CHAMBERLIN. It is dated in April, and it states that DOL-OWCP had a copy of the claim completed by Mr. Chamberlin dated on October 18th and that they request why the FBI hasn't began processing it.

The next memo was a memo from Department of Labor, and it indicates here, this is approximately 1 year later, my entire package from my file was returned to me. And it states, "This person is not a Federal employee. We are returning the materials you have submitted for your disposition." The memo is not signed, does not bear a name. It just returned the entire package.

That was what I had encountered in trying to file the claim.

Following that, the second segment was and is going to review process.

After having filed the claim, I had inquired with William Israel, the claims examiner, to see if he had received my package. There had been a total of six mailings, all registered return receipt. This is exhibit 3. And on that the exhibits are signed bearing a similar signature from a DOL-OWCP employee, and the dates range from September 1996 up to and including March 1998.

Of significance is the one on November 25, 1996. This is the reconsideration I had submitted to Mr. Israel, and Mr. Israel had stated he had not received the package. However, it is the same signature that the other five bear.

Following this is what I have labeled as the notorious Karen Mendernach homicidal-suicidal memo. After having been targeted as a whistle-blower, on July 19, 1993, Special Agent Mendernach prepared a confidential memo to FBI headquarters and FBI management in Detroit stating, "Chamberlin may be emotionally or mentally unstable. Several agents believe he may be a danger to himself as well as to others. The agents requested anonymity."

This report I have been unable to obtain for quite a period of time. My attorneys, my treating doctors had requested it, and I had pleaded with the Department of Labor, Office of Workers' Compensation Programs, to obtain the document, but to no avail. However, it was released on August 5, 1998, through a congressional inquiry from Honorable David Price. And that is the fifth exhibit.

The final exhibit is a memo from Marilyn Preuit, a hearing representative, and this is the denial of my last reconsideration. And in that she specifically states, "If you disagree with this decision, you have the right to appeal before the Employees' Compensation Appeals Board."

Additionally, I had talked with Stephanie Stone as well as Deputy Director Sheila Williams in regards to do I have the right to appeal for a reconsideration. Ms. Williams specifically told me that she did not have that answer and that she would have to do the research to find out if I had the right for reconsideration.

Concluding, the DOL-OWCP also maintains the position it is a security matter. I challenge this, for during the Merit Systems Protection Board in December 1994, Administrative Law Judge Nina Puglia had informed my attorney that it was an open court matter and that it was open to the public. Additionally, OWCP claims security, while the FBI has only produced approximately 20 pages,

while the claimant has submitted over 1,000 pages of FBI documents, all of which are unclassified.

In conclusion, Mr. Chairman and distinguished members of the subcommittee, I would again like to personally thank you for allowing me to participate in this hearing.

[The prepared statement of Mr. Chamberlin follows:]

Statement of Thomas Mike Chamberlin before the
Subcommittee on Government Management, Information and Technology of the
House Committee on Government Reform
Presented on Tuesday May 18, 1999 during the Hearing on
**"OVERSIGHT OF CUSTOMER SERVICE AT THE OFFICE OF
WORKERS' COMPENSATION PROGRAMS"**

Mr. Chairman and distinguished members of the subcommittee, thank you for providing me the opportunity to present the barriers I have encountered in the process of filing a worker's compensation claim with the Office of Workers' Compensation Programs with the intent to provide a synopsis of DOL-OWCP's action for analysis to improve "effectiveness and efficiency".

BACKGROUND

Upon graduation from high school I joined the United States Marine Corps. I proudly served a tour in Viet Nam and was involved in several skirmishes, the most notable was the attempted siege of Khe Sanh in 1968. I was honorably discharged in September 1968 and received several medals/commendations one of which was a Purple Heart for shrap metal wounds sustained to the arms and legs.

Following my military career, I began working construction in my hometown area of Pittsburgh, Pennsylvania. After a few years of wandering, I met my lovely wife (to-be), Terry Bruno. We began to focus on a family and a career.

I began my law enforcement career in February 1972 with the Metropolitan Police Department, Washington, DC. We were married in May 1972. Our family and careers began to evolve. I remained with the MPDC until December 1979 at which time I received an appointment as a Special Agent with the Drug Enforcement Administration (DEA). In March 1984, I received an appointment as a Special Agent to the Federal Bureau of Investigation (FBI), the believed to be "premier law enforcement agency".

I had a distinguished law enforcement career until September 1990; I reported FBI wrongdoing to the Chief Judge of the United States Federal Court, Eastern District of Michigan involving improper actions surrounding Title III matters (wiretaps). The FBI conducted its own internal investigation. My law enforcement career began a downward spiral.

In the summer of 1993, another individual brought forth similar allegations of FBI wrongdoing. During this period, FBI personnel including management began to attack my character. Several agents reported I was homicidal-suicidal, however, they requested confidentiality. I have been unable to identify these agents. Via a congressional inquiry last summer, 1998, I did receive the notorious "Karen Mendernach Homicidal-Suicidal Memo" documenting such unsubstantiated allegations.

Additionally, agents reported I was paranoid, claiming black heritage and not trustworthy. More significant, five agents reported I assaulted one of them with a firearm. Interestingly, these five agents reported the alleged action twenty-two (22) months after the alleged assault. The FBI began their focus on terminating my law enforcement career. I was removed from the "rolls of the FBI" in September 1994 for failure to cooperate on an internal investigation I initiated.

It should be noted when I began my law enforcement career I also began higher educational pursuits. During my 23 years while working as a full time law enforcement officer I earned the following degrees: AA & BA in Law Enforcement, Masters of Forensic Science, Masters of Public Administration and completed all coursework towards a Ph.D. This final pursuit was placed in a stalemate due to the FBI's actions.

OWCP CLAIM

Barrier One - Filing a Claim

The actions of the FBI placed insurmountable stress on me. Subsequently, I filed an OWCP claim on October 17, 1995 with the appropriate paperwork forwarded to my former employer, the FBI for their action. A claim which has yet to be finalized. All correspondence initiated by the claimant to either the DOL-OWCP and/or the FBI was sent certified return receipt with the appropriate documentation maintained. Additionally, numerous telephone calls occurred between the claimant and the respective parties during this entire process.

On January 8, 1996, DOL-OWCP Supervisor Stephanie Foster returned my file stating DOL-OWCP did not have a case file, therefore, file being returned.

On January 16, 1996, I submitted the file for a second time to DOL-OWCP following telephonic conversation with OWCP personnel with the appropriate paperwork forwarded to the FBI requesting action for the second time.

On March 3, 1996, I submitted a follow-up letter to both DOL-OWCP and the FBI to determine the claim status. I also had several additional telephonic conversations with DOL-OWCP but to no avail.

On April 3, 1996, DOL-OWCP Technical Advisor Kevin Finn returned my file stating he needed my employer's (FBI) completed paperwork before he could begin the process.

On April 26, 1996, DOL-OWCP Supervisor Chris Brandstrip submitted a letter to FBIHQ "requesting FBI compliance".

On July 19, 1996, I submitted a complete file to Honorable Robert Reich, Secretary of Labor, requesting assistance. I also stated DOL-OWCP had a complete file in their possession.

On July 29, 1996, Lee Haywood of DOL-OWCP left a message on my answering machine my file would be forwarded to Supervisor Stephanie Fenton.

On August 1, 1996, DOL-OWCP returned my entire file with a note enclosed stating, "... THIS PERSON IS NOT A FEDERAL EMPLOYEE." The DOL-OWCP document did not contain the name of any individual. It just stated, "WE ARE RETURNING THE MATERIALS YOU HAVE SUBMITTED FOR YOUR DISPOSITION."

On August 8, 1996, Claims Examiner William Israel accepted Chamberlin's DOL-OWCP claim for review.

In summary it took more than 10 months, over 6 mailings, unlimited calls and action by the Secretary of Labor to initiate the filing of the claim.

Barrier One could have been overcome by DOL-OWCP having competent employees and a SOP (standard operating procedure) in place with monitoring to ensure compliance.

Barrier Two – Employer's (FBI) deceptive action: DOL-OWCP's inaction

I pleaded from the on-set of the filing of the claim for the FBI to produce the notorious "Mendernach Homicidal-Suicidal Memo" and all FBI documentation surrounding the FBI's character assassination. I stated it was my belief the FBI is and would continue to withhold the documentation. Subsequently, I pleaded for assistance from DOL-OWCP in obtaining the documents.

My position was the documents would establish one of two things, the claimant's mental health problem or the employer's action (character assassination) caused severe stress resulting in depression.

1. FBI personnel including management according to FBI documentation found the claimant to be suffering from a mental illness while in the performance of his FBI Special Agent duties. The claimant was of sound mind at the time he received his FBI appointment and routinely passed his annual physicals as well as his required updated top secret security clearances. Therefore, the mental illness evolved while in his performance of duty. It would be in the employer's own documentation.

A specific example of this is on two occasions, 9/17/93 and 10/06/93, FBI management in the Detroit Division requested authorization from FBIHQ to order the claimant to "undergo psychiatric evaluations." The FBI refuses to produce all relevant documents surrounding the psychiatric requests. DOL-OWCP refuses to assist the claimant in obtaining the documents. The claimant was never ordered to undergo a psychiatric evaluation by the FBI.

2. The FBI's calculated actions in the ploy to destroy my character, i.e. character assassination, placed insurmountable stress on me resulting in a case of chronic depression. I contend I was a healthy, normal individual in the summer of 1993. I was performing fully successful as a Special Agent with the FBI per my two latest performance reports dated 4/01/93 and 9/10/93. I was nearing completion of my Ph.D. coursework at Michigan State University and serving as an adjunct professor at the University of Detroit-Mercy. Additionally, I was active in volunteer community action such as- youth baseball and soccer coach, on the Board of Directors Community Drug Program, juvenile mentor via local courts, religion instructor at church and co-chairperson for a funding project for the year 2020 involving six police departments.

I was fulfilling my dreams, i.e. a happy family (loving, beautiful wife, 2 great daughters, one in college and one starting in September '93, a nine year son who was perfect and a true friend), a fulfilling career and in a position to serve society in professional and volunteer basis.

My contention was the allegations the FBI was making attacking my character were false. Furthermore, the FBI was withholding said documents but was continuing to pursue my demise. For example, in the fall of 1993, the "bureau" pursued criminal prosecution by presenting unsubstantiated acts to the United States federal prosecutor. Eventually, all potential criminal charges were ignored by the US Attorney's Office in Detroit, Michigan as well as the US Department of Justice in Washington, DC.

The false allegations, beginning in July 1993 with the notorious "Mendernach Homicidal-Suicidal Memo" resulted in undue stress and chronic depression, due to the lack of organizational integrity. "The institution was more important than the individual. Integrity was idealistic and a sign of ineptness."

I contend I was a healthy individual. The character assassination brought on by my employer, the FBI, was false. However, these false allegations would destroy anyone.

Barrier Two should have been handled by DOL-OWCP personnel, i.e. retrieval of relevant employer documents. However, it was obvious the Office of Workers' Compensation Program had joined allegiance with the employer, The FBI. From their decisions it was clear they did not want to review my case file in its entirety nor would they require the FBI to produce any documents I vehemently pleaded for.

The FBI had provided DOL-OWCP with approximately 20 pages excluding my application and various standard forms. I provided DOL-OWCP with an excess of 1,000 pages of FBI documentation prepared by FBI personnel and relating to my character. Said documents were retrieved via various legal channels. However, I was unable to retrieve several specific documents such as the notorious "Mendernach Homicidal-suicidal Memo" and the paperwork surrounding the order for FBI psychiatric evaluations. The FBI refused to produce the documents in previous legal arenas and continued to ignore my request via the DOL-OWCP claim.

Gloria McCray Watson, Supervisory Claims Examiner, clearly presented DOL-OWCP's position in her letter to the claimant on 5/21/98. I had previously inquired as to any FBI documents in the DOL-OWCP file, which I had yet to receive. Specifically, I was inquiring about the aforementioned FBI documents. Ms. Watson stated "we have reviewed your file and have determined that there are no records of this kind in your file (emphasis added). She further stated, "We have not nor the FBI had reason to correspond since August of 1996."

Ms. Watson made it clear DOL-OWCP had no interest in the "Mendernach Homicidal-Suicidal Memo" nor any other FBI management documentation regarding the claimant's psychiatric condition be it TRUE or FALSE. Note, the file was first accepted for review by DOL-OWCP in August 1996

Barrier two is a serious organizational deficiency and DOL-OWCP upper management should be held accountable for this "inefficiency and ineffectiveness." Barrier two must be addressed via congressional action.

Barrier Three DOL-OWCP's adversarial position in the decision making process.

DOL-OWCP's position was clearly established from the onset of accepting the claim, i.e. either dismiss the claim or get it removed to the Employee's Compensation Appeals Board (ECAB). Mr. Israel's first correspondence, dated August 8, 1996, provided a detailed list of questions, many of which had already been addressed in my initial package in filing the claim. He concluded by stating a reasonable response time is 30 days. He then stated, "If we have not received the requested information, an indication that it is forthcoming, or evidence that the information is not necessary to decide your claim, we will be requested to render a decision on your claim based on the evidence in file."

On August 29, 1996, I responded to Mr. Israel's request. I submitted a ten-page response to his questions along with over 50 pages of FBI documentation relating to my character/mental health be it positive or negative.

On September 5, 1996, Mr. Israel responded by stating "Your employer provided full and complete documentation with your application for worker's compensation benefits." He further stated " ... your (Chamberlin) August 29, 1996 mailing failed to fully respond to our letter". He concluded that if I failed to provide a complete response within 30 days, the claim would be adjudicated based on the evidence of record. Note, the FBI reportedly " ... provided full and complete documentation..." even though the "Bureau" did not provide the homicidal-suicidal memo or any documents relating to the orders for psychiatric evaluation.

On September 29, 1996, I submitted a response to Honorable Robert Reich, Secretary of Labor; Shelby Hallmark, Director, ESA-OWCP, and Mr. Israel. The response included 28 exhibits and in excess of 100 pages all relating to the claimant's condition.

On October 17, 1996, I submitted a follow-up letter to the aforementioned 3 parties stating my three doctors had submitted medical requests to my former employer, FBI, and the FBI refused to comply with any of the three doctors' requests. I pleaded for assistance from DOL-OWCP.

On October 10, 1996 DOL-OWCP disallowed my claim. The memorandum stated, "As of this date, evidence sufficient to support that the claimant sustained an injury has not been received." Note the DOL-OWCP refused to assist the claimant in obtaining the relevant employer documentation requested by the claimant's three treating doctors.

On November 20, 1996 I submitted my first request for reconsideration. Said letter was sent certified return receipt requested. A DOL-OWCP employee who had signed for several of my previous letters received the letter.

On February 1, 1997, approximately 3 months later, I telephonically contacted Mr. Israel to determine the status of my reconsideration. Mr. Israel informed me he had never received the reconsideration. He was unable to account for the DOL-OWCP employee acknowledging receipt of it on November 25, 1996.

Numerous forms of communication followed between DOL-OWCP and the claimant for the next 4 months via telephone, fax and US mail.

On July 15, 1996, DOL-OWCP denied the claimant's first reconsideration.

Within the next 2 years, the claimant submitted 3 additional requests for reconsideration. I had in excess of 50 occasions to communicate with DOL-OWCP personnel in various formats (phone, fax and mail) pleading for their assistance in obtaining the relevant employer documentation and to review the file in a fair and equitable manner.

The claimant had submitted to DOL-OWCP six different doctors' reports, some of which were required to submit follow-up reports to DOL-PWCP. Additionally, one of the doctor's deposition which was taken by the FBI was submitted. The claimant also submitted hundreds of pages of FBI documentation attacking the character of the claimant and/or documenting the claimant's mental problems. However, the FBI refused to produce certain documents and DOL-OWCP refused to assist the claimant in obtaining the relevant documents.

Congressman David Price successfully obtained the notorious "Mendernach Homicidal-Suicidal Memo" in August 1998 after 5 years of requests by the employee, treating doctors, attorneys and senators. The FBI continues to withhold several other relevant documents.

The DOL-OWCP ignored the "Homicidal-Suicidal Memo" in their denial for the third request for reconsideration. In the Memorandum to the Director outlining the decision it did not address the memo. Note this is a memo prepared by the employer stating the employee is "homicidal-suicidal". The FBI withheld it from the employee for 5 years; DOL-OWCP receives it and ignores it in their decision-making process.

On January 11, 1999 I submitted my fourth request for reconsideration. Said request contained the notorious "Mendernach Homicidal-Suicidal Memo" along with a report from one of my treating physicians, a rheumatologist.

The DOL-OWCP states its reviews are conducted within a 90-day period. As of Friday May 14, 1999, 125 days have elapsed and I await the "decision"

A final yet as significant issue regarding DOL-OWCP adversarial position is their desire to expeditiously remove the claim from within OWCP and refer it to the Employee's Compensation Appeals Board (ECAB). The claimant has three appeal processes: reconsideration, oral hearing or ECAB. DOL-OWCP chooses to refer the claimant as soon as possible to ECAB without concern of the claimant. ECAB is the claimant's final appeal. Thereby, denying him/her other viable appeals such as if one was to pursue a reconsideration. By placing the claim before ECAB it removes the claim from DOL-OWCP's responsibility for ECAB is a separate entity within the Department of Labor but apart from OWCP.

DOL-OWCP's adversarial position and deceptive action is clearly set forth in Marilyn Preuit's (DOL-OWCP Hearing Representative) letter dated 11/05/98. Said letter is the denial of claimant's third reconsideration. This denial completely ignored the "Mendernach Homicidal-Suicidal Memo". Ms. Preuit states, "If you disagree with this decision, you have the right to appeal to the Employees' Compensation Appeals Board for review of the decision."

Subsequently, I contacted Claims Examiner Stephanie Stone as directed by Director Thomas Markey to determine if I had the right to file another "reconsideration". Ms. Stone evasively responded to follow my appeal rights in the letter but did not acknowledge the reconsideration issues.

On November 13, 1998, I faxed the specific question - "Do I have the right to file a reconsideration ...?" along with the appropriate legal citation to Director Markey/Assistant Director Sheila Williams. I followed up the fax with a telephone call to Ms. Williams. The Assistant Director, Sheila Williams, advised me, "she would have to do research regarding the right to file for reconsideration." She added she would be traveling the week of November 16, 1998 and would get back with me in a few weeks." She never returned the call.

Barrier three is also a serious organizational deficiency and DOL-OWCP upper management is responsible for this major organizational flaw, an adversarial position greatly diminishing the professional standards of the organization. Barrier three must be addressed via congressional action.

In conclusion, my greatest loss was as a result of my employer's actions. DOL-OWCP's inaction has helped to exacerbate my personal, physical/mental, and financial condition. Since September 1994 I have had four jobs and currently unemployed. Additionally, I have changed residences on four occasions due to financial restraints. Submitted several hundred job applications including over 50 state applications in North Carolina; all to no avail. My personal health continues to deteriorate. My medical condition includes diabetes and anemia plus other vascular problems all rooted in and as a result of depression.

I would again like to personally thank, you Mr. Chairman, and distinguished members of the Subcommittee for allowing me to participate in this hearing with the intent to improve governmental operations.

Documentation to substantiate my statement is available upon request.

Mr. HORN. Let me just pick up one question to clarify the exhibits.

You mention the July 19, 1993, memorandum from Karen Z. Mendernach to James R. Perez, Equal Employment Opportunity officer. You note that throughout your testimony and call it notorious, and you say they are documenting such an unsubstantiated allegation. Did this individual, Karen Mendernach, ever talk to you, ever examine you in any way?

Mr. CHAMBERLIN. No, she didn't. I had requested this memo; and, as of August 1993, I had never been able to retrieve it and the FBI was in denial of the actual document.

Mr. HORN. How large is this document? Is it just this one-page memo? Are there attachments to it? Or what have you found out?

Mr. CHAMBERLIN. Sir, through various avenues of litigation, I have determined that there are several other documents surrounding it. I have seen ASAC Stapleton had referred to this; and during interviews in regard to these agents I have been unable to obtain any of those documents.

Mr. HORN. So, you feel those documents do exist. People have based judgments on them, and yet you cannot get a copy of that, even though it concerns you. And, you would think if they are going to give a psychiatric exam, you would remember it?

Mr. CHAMBERLIN. Yes, sir.

Mr. HORN. And they didn't give a psychiatric exam.

Mr. CHAMBERLIN. Correct. On two occasions, I believe it was September 17th and October 6, 1993, FBI management in Detroit had requested a psychiatric exam, unbeknownst to me. And I don't know what documents evolved from that, and I was never required to submit for a psychiatric exam, and they refused to present any of the documents. And my doctors have made over 20 requests, as well as the attorneys, to obtain documents relevant to it; and the FBI refused to comply.

Additionally, I have pleaded with the Department of Labor, Office of Workers' Compensation Programs, for assistance. And claims examiner—I believe it was Gloria Watson had informed me that she had obtained sufficient documents, and that would be roughly these 20 pages from the FBI, and that they were not going to require them.

Mr. HORN. Do you know if Karen Mendernach is an M.D.?

Mr. CHAMBERLIN. No, she is an FBI agent with a Bachelor's degree.

Mr. HORN. So she doesn't have a medical degree.

Mr. CHAMBERLIN. Correct.

Mr. HORN. She is not a registered, board-certified psychiatrist; is that correct?

Mr. CHAMBERLIN. Correct.

Mr. HORN. And yet she is making these judgments.

Mr. CHAMBERLIN. Correct.

Mr. HORN. Do you know if she ever interviewed people that worked around you and have a list of those interviews somewhere?

Mr. CHAMBERLIN. To my knowledge, she did interview, just referring to the memo. But they requested anonymity. And I addressed Rita Harrington, the Employees' Assistance Coordinator, pleading for these while I was an agent, stating that the FBI was letting me

carry a loaded weapon around the office with these allegations, but they all refused.

Mr. HORN. I would think it is a little difficult for agents to request anonymity if they can simply libel a fellow worker, and I can't believe that kind of stuff would go on. I am surprised the FBI would permit that.

If they want to go to board-certified psychiatrists or psychologists, that's one thing, but just to have particular views of fellow workers and think you should give that any credence boggles the mind.

So, you don't know about any more attachments to that. Presumably, those would be where they say several agents believe he may be a danger to others as well as to himself. The agents requested anonymity. Well, you are saying there's probably a file there somewhere and you have never been allowed to counter that file; is that correct?

Mr. CHAMBERLIN. Correct, sir. During my dismissal with the Merit Systems Protection Board we were able to obtain documents where the ASAC had referred to interviewing a number of agents and various documentations, as well as to request for the two psychiatric evaluations. However, the FBI has refused all of our requests.

Mr. HORN. Now, you say on page 3 of your testimony the claimant was never ordered to undergo a psychiatric evaluation by the FBI. Did they ever ask you to undertake such an evaluation?

Mr. CHAMBERLIN. Never, sir.

Mr. HORN. You note that Congressman David Price, one of our most esteemed Members here, successfully obtained the notorious memo to which we have referred here; and in August 1998, after 5 years of requests by the employee, treating doctors, attorneys, and Senators, the FBI continues to withhold several other relevant documents. Such as what? What do you surmise they still have?

Mr. CHAMBERLIN. Such as the interviews in regards to these agents. Such as all the documentation—when FBI management in a division requests a psychiatric evaluation, they must submit written documents to support their request for the psychiatric evaluation and, in turn, FBI headquarters will respond back to them in a written document.

And so, therefore, there were two requests, and I have been unable to obtain the documents pertaining to the two requests, the documents that would support the two requests, as well as FBI headquarters documents that would either support the request or deny the request.

Mr. HORN. Well, thank you.

Mr. HORN. We will now move to Ms. Dianne McGuinness, former employee of the Social Security Administration. Ms. McGuinness.

Ms. MCGUINNESS. Thank you. I wish to thank you for the honor of being here today. I am here to tell you about my frustrations with customer service at the Office of Workers' Compensation Programs. There are a few concerns I wish to discuss today, and while these are only two or three concerns, the magnitude is far greater.

Mr. Kenneth Hamlett, Regional Director of the New York Office of Workers' Compensation Programs, threatened to deny my claim over and over if I went to my Congressmen. He told this to Miriam

Madden, Director of Senator Alphonse D'Amato's office, on September 18, 1996; and she called me to tell me so. I submitted a copy of her statement for the record.

Title 5 U.S.C. 7211, Employee's Right to Petition Congress, states, "The right of employees, individually or collectively, to petition Congress or a Member of Congress, or to a committee or member thereof, may not be interfered with or denied."

There are times when I needed congressional assistance and assistance from my union representatives. These times arose when I could not get through on the telephones at the OWCP because they were either busy, the mailbox was full, or nobody returned my calls or answered my letters.

I had problems getting copies of my file. Every few months I would ask for the current part of my file that I did not have. My informal requests were ignored, and my formal requests under the Privacy Act were ignored. I was even referred to as a liar by a claims examiner when my union explained the need for my file so that I may address my pretermination appeal.

When I finally did get a copy of my file, there were 97 pages of someone else's doctors' reports, memorandums, personal letters, et cetera, in my file. I contacted the other Federal injured worker, in another State, 1,500 miles away and in a different region, to tell him what I had found. I also contacted his Congressman, and we both contacted Congressman Horn's office to complain. Someone may have parts of my file in their file. I also found a job résumé and several pages from a third person's file. This leads me to believe that my file wasn't worked. If my file was worked, the claims examiner would have found these documents.

I was told that the unit supervisors do the filing. I called Jonathan Lawrence, District Director of the New York office, and I explained how difficult it was to get through on the telephones. Often I would get told from Customer Service they would take a message and a claims examiner would call me back within 3 days. Mr. Lawrence told me in this conversation that if people can travel and go here and there and do everything else, there is a possibility that they are not totally disabled. They can travel and do certain other things but they can't work, and that doesn't make sense to me. If a doctor says a person is unable to work, then they should be unable to leave their homes, he said.

I submitted a tape recording of this conversation to the subcommittee and wish it to be made part of the record.

Mr. HORN. Without objection, it will be put in the record at this point.

[The information referred to follows:]

**Taped conversation between Dianne McGuinness and
John Lawrence, director of the NY District Office of
Workers Compensation Programs.**

Mr. LAWRENCE: Hello.

Ms. McGUINNESS: Hello Mr. LAWRENCE: I was wondering if you, tell me why the doors for your office are closed? Um-- I noticed a sign up on the door that you have to make an appointment a week in advance.

Mr. LAWRENCE: Correct.

Ms. McGUINNESS: Why is that?

Mr. LAWRENCE: Because we have been threatened with our lives.

Ms. McGUINNESS: You have been threatened with your lives?

Mr. LAWRENCE: Yes, we had a man arrested that wears a band around his wrist at all times so we can be alerted when he is in our area and, basically, we are Federal employees we don't want to be shot at.

Ms. McGUINNESS: You don't want to be shot at but don't they have metal detectors? When you come in, I mean, you know, I can't see how somebody can get in with a gun.

Mr. LAWRENCE: They don't require federal employees to go through metal detectors all you have to do is show identification to get into this building.

Ms. McGUINNESS: Ah, that terrible.

Mr. LAWRENCE: We can't afford to risk an incident here.

Ms. McGUINNESS: Oh-- I just wanted to ask you--The claimants don't know and we travel long distance to see you and, we hadn't been notified. I understand this has been the practice for, like six months.

Mr. LAWRENCE: We, don't have the capacity of doing a mass mailing to everyone of clients, That's 76,000 people, which would be something to do that.

Ms. McGUINNESS: Just in the New York Office?

Mr. LAWRENCE: That's right.

Ms. McGUINNESS: 76,000 people.

Mr. LAWRENCE: 76,000 claims, active claims.

Ms. McGUINNESS: Ok, because you know that people who come to see you are generally handicapped and incapacitated and it is hard for them to travel and then when you don't know... This is what happened in my case. If you don't know when you get there-- you know, it is very discouraging. I feel for you, I understand what you are going through, but on the other hand I don't think that the office should be closed to the rest of us.

Mr. L: Safety of my employees comes first.

Ms. McGUINNESS: Oh, I understand that the safety comes first, but isn't there something can't you get help from higher up, plate glass windows, or plexi glass windows or something of that--

Mr. LAWRENCE: Normally if I would like to visit someone, I would call. If I had a business appointment I would call, I wouldn't just come down here.

Ms. McGUINNESS: Yes, but it can be very hard,-- no that's not the case sometimes you just can't get through you can leave messages and people will say they will get back to you in forty eight hours and they don't. You know, you stay home and you wait by the phone and you believe that someone is going to call you and they don't call.

Mr. LAWRENCE: We--

Ms. McGUINNESS: I am sorry what was that? I can't hear you.

Mr. LAWRENCE: We would think that if someone was unable to work that they wouldn't have anywhere to be but by the phone. Why would I be anywhere else?

Ms. McGUINNESS: I am sorry. I don't understand the question. Why would they be anywhere else?

Mr. LAWRENCE: With the exception of their doctors, that if someone is unable to work they shouldn't be anywhere but in their home. It just seems to me that people can travel, go here and there, then there is a possibility they are not totally disabled.

Ms. McGUINNESS: That's not true. People can be injured without being confined to their homes, when they can't work.

Mr. LAWRENCE: Totally can't work? What type of work can they be employed by?

Ms. McGUINNESS: Yeah, so.

Mr. LAWRENCE: Totally disabled-- but they can shop, they can travel, they do certain other things, but they can't quote, unquote--"work." That doesn't make sense to me.

Ms. McGUINNESS: Well then that is up to the doctor then really, I would think.

Mr. LAWRENCE: Who am I specking with?

Ms. McGUINNESS: Umm,-- I just want to ask you something. If your office is open, see I just don't understand your thinking, well maybe you can explain it to me. The office is supposed to be--

Mr. LAWRENCE: Why don't you tell me who you are?

Ms. McGUINNESS: I don't think that is necessary.

Mr. LAWRENCE: Well, I am sorry. I am going to have to end the conversation, because I don't know who I am talking to.

Ms. McGUINNESS: Thank you, Mr. Lawrence..

Ms. MCGUINNESS. I was also sent to an OWCP doctor for a neurological examination. I had my shoes on, all my clothes on, and the doctor told me he was in a rush. He did not touch my upper extremities or lower extremities during his examination. He did not perform any clinical tests to determine injuries to my upper extremities except for me to have him squeeze his hand. His bill for this examination was \$285. The examination was less than 4 minutes, and it seemed that his charge was—he was being paid \$75 a minute for this service. His examination resulted in a conflict of medical opinion.

I submitted a tape recording to the subcommittee of this examination, and I wish it to be made part of the record.

Last, it was Mr. Kenneth Hamlett, Regional Director of the New York office's treatment of me when I went to the office with my union president for a prescheduled appointment. The Regional Director told me that he was denying my physical therapy, sending me back to work very soon, sending me for a referee examination, ignoring my pretermination appeal, refusing me the right to participate in the selection process of an impartial physician, and denied me the right to see my file in person.

I needed that file. I had a few more days left before I could complete my appeal, and I believe that he denied me the right to see my file so that my appeal would not be as complete as I would have liked it to be.

He also threatened to have me removed by guards if he ever found me on the 7th floor without an appointment. I feel that Mr. Hamlett, in his capacity of Regional Director, was practicing medicine when he denied me my physical therapy; and, based on Mr. Kenneth Hamlett's statements, I assert that the outcome of my claim was predetermined so that I couldn't collect my legitimate benefits. He violated my rights, and the processing of my claim was at the direction of Mr. Hamlett.

I defer any further testimony to Mr. John Riordan, then union president of AFGC 3369, who was present during my encounters with Mr. Hamlett.

And I would like to add one thing: this statement took longer than Dr. Bloom's examination. I thank you and I welcome your questions.

Mr. HORN. Well, thank you very much.

[The prepared statement of Ms. McGuinness follows:]

STATEMENT OF DIANNE MCGUINNESS
BEFORE THE
HOUSE GOVERNMENT REFORM AND OVERSIGHT COMMITTEE
GOVERNMENT MANAGEMENT, INFORMATION AND TECHNOLOGY
SUBCOMMITTEE
MAY 18, 1999

My name is Dianne McGuinness. I wish to thank you for the honor of being here today to tell you about my frustrations with Customer Service at the Office of Workers Compensation Programs.

As background, I sustained work-related injuries while employed with the Social Security Administration. Historically, as per my evaluations, I was a highly motivated, dedicated employee. I had 23 years of Federal Service and received Excellent and Outstanding reviews and many cash awards.

Several months after my claim had been accepted, I contacted the New York District Office concerning wage loss compensation. I was not able to get an answer and called Mr. Kenneth Hamlet, Regional Director. Mr. Hamlet stated that I would receive a check in about a week, but I must now decide to return to work or retire.

Not receiving my check as promised, I called Mr. Hamlet to follow-up. He stated that steps were being taken to get me back to work. I had not yet completed a prescribed course of physical therapy, when Mr. Hamlet said he was sending me back to work. He said he would have the claims examiner call me back because he did not have my case file.

I received a letter of entitlement telling me how much my first check would be and in the same letter, I was told I would be sent for a Second Opinion examination.

Upon learning about the upcoming Second Opinion examination, I requested the "Statement of Accepted Facts, Issues to be resolved, and Questions to be asked. I did not receive a response. My union requested same, and did not receive a response. I then contacted my Congressman. Mr. Kenneth Hamlet, Regional Director, responded to the Congressman that I would not be sent the Issues to be resolved, and questions to be asked, until after the examination in order to preserve the integrity of the examination.

Yet, the law provides that I am entitled to these if I ask for them.

I submitted a copy of Mr. Hamlet's letter to the subcommittee and wish it to remain part of the record.

I then attended the Second Opinion Neurologist Examination. Dr. William H. Bloom was the examining physician and he spent less than 4 minutes with me. I was fully dressed and had my shoes on. My injuries were to my neck, lower back, and upper extremities. There was no touching by the doctor to my upper extremities and I was not asked to perform any maneuvers with my upper extremities. Yet, his examination constituted the "Weight of Evidence" and I was sent a Pre-termination letter. Notes from the file show that my agency had been calling OWCP for the results of the Second Opinion Examination. OWCP informed my agency that it would be a few more days. Incidentally, I have a Memorandum from my agency that indicates that they can call for Second Opinion Examinations. Dr. Bloom's bill for the "less than 4 minute Exam" was \$285.00.

I submitted a tape recording of the examination to my claims examiner. I also submitted a tape recording and Dr. Bloom's bill to the subcommittee.

I mentioned to Mrs. Miriam Madden, Executive Director, Senator Alphonse D'Amato's office that I had to get my argument to the Proposed Termination to the Office. She made an appointment for me with Ms. Johnson of the New York Office.

Upon arriving at the Office's door with Mr. John Riordan, Union President, AFGE, 3369 we heard someone shouting at us from down the hall. It was Mr. Kenneth Hamlet, Regional Director. He was shouting at us, as though we had committed a crime. I will defer testimony regarding what took place on our visit to the Dept of Labor to Mr. Riordan who will testify today. I have submitted copies of Affidavits by Mr. Riordan to the subcommittee and wish the affidavits to be made part of the record.

Two days later, I met with Mr. Riordan in the Union Office. Mr. Hamlet called me at the Union office. I will once again defer testimony about the details of this conversation to Mr. Riordan.

I would like to mention that Mr. Hamlet stated he would ignore my argument to the proposed termination and arrange a Referee exam and he added "And it will be very soon. Mrs. McGuinness". I received an overnight letter directing me to go to a Referee exam by a physician who

Mr. Hamlet picked without any input from me. Yet, another claimant was permitted to participate in the selection process of the Referee.

After the meeting and phone call with Mr. Hamlet, I receive a phone call from Miriam Madden of Senator Damato's office. She tells me that Mr. Hamlet threatened to deny my claim over and over if I went to my congressionals. I feel the environment is such that the outcome of my claims was pre-decided. I have submitted Mrs. Maddens statement to the subcommittee as part of the record.

Title 5 USC 7211, Employees Right to Petition Congress states, "The right of employees, individually or collectively, to petition Congress or a member of Congress, or to a committee or member thereof, may not be interfered with or denied.

Most months my checks were not sent out timely and I had to contact the office multiple times to get my checks.

Requests for current copies of my file were ignored after about 10 months of letter writing and I received an incomplete copy only after I was terminated. Upon review of my file, I discovered 97 pages of Doctors Reports and other related documents belonging to an injured worker that resides out of state and in another Region. I contacted this injured worker and his congressional. He stated that his congressional did not want me to have his file because of the privacy issue, but that my having it did not concern him, what concerned him was that OWCP misplaced parts of his file. What concerns me is that someone may have parts of my file with my doctors reports. I made a photocopy of the 97 pages and sent them to this injured worker. The worker informed me that he contacted the subcommittee to express his concern. I provided the subcommittee with a copy of the letter I sent along with the 97 pages of doctors reports, etc. for the record.

In a telephone conversation with Mr. Jonathan Lawrence, District Director of the New York Office, Mr. Lawrence stated to me, that if people can travel and go here and there and do everything else, there is a possibility that they are not totally disabled, but they can travel and do certain other things, but they can't work, that doesn't make sense to me. If the doctor says a person is unable to work then they should be unable to leave their homes. I submitted a tape of this conversation to the subcommittee and wish it to be made part of the record.

The rudeness when I appeared for a pre-scheduled meeting, failure to pay me on time each month, threats to cut off my medical treatment, threats to deny my claim because I engaged the help of my congressionals, failure to provide me with a copy of my file under the privacy act, failure to return my phone calls, ignoring my appeals, is very very poor customer service. I was an employee of the Social Security Administration and I provided Excellent Service to the customers. I expect to be treated with courtesy and I expect Excellent service from OWCP.

While these are just a few complaints, the magnitude must be greater. I have additional concerns and additional tapes that I wish to share with the subcommittee in the future. These tapes contain conversations of myself and OWCP examining physicians and claims examiners. One in particular contains statements made by, OWCP examining physicians that the claims examiner ordered duplicative, invasive, expensive, diagnostic testing. And that the claims examiner discussed this over the telephone with the examining physicians. I feel that it is highly improper for a claims examiner to hold exparte telephone conversations with an impartial examiners and instruct the impartial examiner to perform diagnostic procedures. When I asked the examiners the medical necessity for these tests, the examiners informed me that Mr. Eric Beluja and Mr. Kevin Kates ordered the tests and that everything was done by telephone. The doctors told me that the tests were ordered before the appointments were made. One would think that it would be a physicians decision to order any testing based on clinical findings and medical necessity and not prescribed by, or ordered by a claims examiner or any other employee. Mr. Eric Beluja, claims examiner did not think it was excessive for taxpayers to foot eight thousand dollars for duplicative testing.

Mr. HORN. We now move to Mr. Fairbanks, Matthew Fairbanks, Special Agent/Pilot, Drug Enforcement Agency.

Mr. FAIRBANKS. Chairman Horn and members of the subcommittee, thank you for the opportunity to testify today on the topic "Oversight of Customer Service at the Office of Workers' Compensation Programs."

My name is Matt Fairbanks, and I am currently employed as a special agent with the U.S. Drug Enforcement Administration. Although I am an employee of DEA, I am appearing today as a private citizen, not as a Department of Justice employee or a DEA employee.

My current duties are that of aviation specialist. I'm a pilot for the DEA. The job requirements in this position have taken me all over the United States and into Central and South America.

On September 25, 1998, I was involved in a training flight accident. The flight was a beginning to transition myself into the helicopters. During the flight, my flight instructor demonstrated a very aggressive maneuver. As the terrain rushed up toward our OH 6 helicopter, I knew we were in serious trouble. With a loud crash, my instructor was killed; and I found myself trying to escape the burning wreckage. I wanted to get my instructor out also, but the flames finally drove me out of the inferno.

I was life-flighted to Parkland Hospital, where I remained for 2 weeks, for which I have little or no memory. Upon arrival at the hospital, my blood pressure was dropping; and I was severely burned over 56 percent of my body. The emergency room physicians discovered that my spleen had been lacerated beyond repair and had to remove it in order to save me from bleeding to death.

I then spent 4 weeks in the Burn Intensive Care Unit. While in the BICU, I had four operations in which viable skin was painfully harvested from unburned areas of my left arm and chest. This was accomplished via a high-tech cheese grater and a press. The tissue is now in place on my right arm and legs, and it continues on its 18-month journey to mature as grafted skin.

After 6 weeks in Parkland Memorial Hospital, I was able to return to my home. My wounds were still open, and my care necessitated a daily nurse visit for IV antibiotics and wound cleaning. All of this was arranged by my workers' compensation case worker, Ms. Sue Maraglino. Additionally, I was required to make a 50-mile round trip to the hospital on a daily basis for therapy and wound care. Once again, all the arrangements, down to the transportation, were taken care of by my caseworker, Ms. Maraglino.

As a nurse, Ms. Maraglino was able to answer all of my family's questions and address all of our concerns; and, as a caseworker, she was also attended to the important doctors' appointments which I had. To this day my recovery has not been hampered due to lack of funding, and I have been carefully informed about what to expect in the future and future surgeries.

Over the months of my recovery, I have had numerous occasions to reflect upon my experiences as a DEA Special Agent. I recall my mission to the Oklahoma City bombing site. I was there as part of my duties as a Special Agent. However, others were there volunteering, volunteering their time trying to help in a hopeless situation.

Various church groups and workers set up dinner banquets on a daily basis at our base of operations, with no charge. A construction worker, seeing my DEA jacket, approached me just to shake my hand and thank me for helping them take care of their own. Schoolchildren made signs and posters which were hanging everywhere. There was one in our bathroom hanging over the mirror which read, "You are looking at a hero." A man stood at the entrance to the work area with little bags of cookies. He told us, "My daughter made these for you. Please take a bag of cookies. It is her contribution." Even country singer Garth Brooks made a personal phone call to the son of DEA Special Agent Kenny McCoullough, who was killed in the blast. This phone call brightened the day of a little boy during a very dark time.

These seemingly small acts provided me with great strength and drive while I was standing on that mountain of rubble, formerly known as the Alfred P. Murrah Federal Building. I could lift the next stone and clear the next level of the building in a continuing search. I did not find anyone alive, but I did find that the great spirit of America was not dead. I previously thought it was.

The same experience which helped me deal with the broken remains of the Federal building laid a groundwork for me in dealing with the shattering conditions of my own life. I'm grateful to a caseworker who provided me with every means at her disposal to help me pick up the broken remains of my life and prepare to go on.

While I lay there in my hospital bed, I recall hearing the news that another teenager in Plano, TX, had lost their life due to an overdose of heroin. It made me think about an event years earlier when I was a Dallas, TX, police officer on the streets of Dallas. I had arrested a poor disoriented junkie. As I checked for weapons, I came across a paper on which he had written the following:

My name is cocaine, call me Crack for short
 I entered this country without a passport
 Ever since then, I've made scum from the rich
 Some have been murdered and found in a ditch
 I'm more valued than diamonds, more treasured than gold
 Use me just once and you too will be sold
 I'll make a school boy forget all his books
 I'll make a beauty queen forget her good looks
 I'll take a renowned speaker and make him a bore
 I'll take your own mother and make her a whore
 I'll make a school teacher forget how to teach
 And I'll make a preacher not want to preach
 I'll take your rent money and get you evicted
 I'll murder your babies, or they'll be born addicted
 I'll make you rob, and steal and kill
 When you're under my power, you'll have no will
 Remember my friend, my name is "Big C"
 If you try me one time, you may never be free
 I've destroyed politicians, actors and heroes
 I've reduced bank accounts from millions to zeros
 I'll make shooting and stabbing a common affair
 Once I take charge, you won't have a prayer
 Now that you know me, what will you do?
 You'll have to decide, it's all up to you
 The decision is one to sit in my saddle,
 It is one that no one can straddle
 Listen to me, and please listen well
 When you ride with cocaine, you ride straight into hell.

My life, my job, my responsibility to you collectively is about removing these soul-destructive elements from our society. Ms. Sue Maraglino's job is to get me back to health so that I can perform that task. She did her job, and as of Tuesday of last week, I am back to do mine.

I'm familiar with the bureaucracy, and I've seen my share of government workers that are professionally "less than anxious." Although others could have had an experience different than mine, I can say that if all caseworkers were as prompt and professional and courteous as mine, nothing more could be expected. Thank you.

Mr. HORN. Thank you very much. That is a very moving statement and quite a poem, I must say.

[The prepared statement of Mr. Fairbanks follows:]

Remarks by

Matt Fairbanks

before the

House Committee on Government Reform
Subcommittee on Government Management,
Information, and Technology

regarding

*"Oversight of Customer Service at the Office of Worker's
Compensation Programs"*

Rayburn House Office Building
Room 2154
May 18, 1999
Washington, D.C.

NOTE: This is the prepared text and may not reflect changes in actual delivery

**Statement of Matt Fairbanks
before the Subcommittee on Government Management,
Information and Technology**

Chairman Horn and Members of the Subcommittee: Thank you for the opportunity to testify today on the topic of "Oversight of Customer Service at the Office of Worker's Compensation Programs". My name is Matt Fairbanks, and I am currently employed as a Special Agent with the United States Drug Enforcement Administration (DEA). Although I am an employee of the DEA, I am appearing today as a private citizen, not as a Department of Justice or DEA employee. My current duties are that of Aviation specialist, and I am a pilot for the DEA. The job requirements in this position have taken me all over the United States, and into Central and South America.

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I was LIFE FLIGHTED to Parkland Memorial Hospital, where I remained for two weeks for which I have little to no memory. Upon arrival at the hospital, my blood pressure was dropping and I was severely burned over 56% of my body. The Emergency Room physicians discovered that my spleen had been lacerated beyond repair, and had to remove it in order to save me from bleeding to death.

I then spent four weeks in the Burn Intensive Care Unit(BICU). While in the BICU, I had four operations in which viable skin was painfully harvested from unburned areas of my left arm and chest. This was accomplished via a high tech cheese grater and a press. The tissue is now in place on my right arm and legs, and it continues on its 18 month journey to mature as grafted skin.

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Over the months of my recovery, I have had numerous occasions to reflect upon my experiences as a DEA Special Agent. I recall my mission to the Oklahoma City bombing site. I was there as part of my duty as a Special Agent. However, others were there volunteering their time trying to help in a hopeless situation.

1. Various church groups set up dinner banquets daily at our base of operations.
2. A construction worker, seeing my DEA jacket, approached me just to shake my hand and thank me for helping them "take care of their own".
3. School children made signs and posters which were hanging everywhere. There was one in our bathroom hanging over the mirror which read, "You are looking at a hero".
4. A man stood at the entrance to the work area with little bags of cookies. He told us "My daughter made these for you", "Please take a bag of cookies, it is her contribution".
5. Country singer Garth Brooks made a personal phone call to the son of DEA Special Agent Kenny McCoullough, who was killed in the blast. He brightened the day of a little boy during a dark time.

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This same experience, which helped me deal with the broken remains of the Murrah Federal Building, laid a groundwork for me in dealing with the shattered condition of my own life. I am grateful to a case worker who provided me with every means at her disposal to help me pick up the broken remains of my life, and prepare to go on.

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My Name is Cocaine

My job, my life, my responsibility to you collectively, is about removing these soul destructive substances from our society. Ms. Sue Maraglino's job is to get me back to health so I can perform that task. She did her job, and as of Tuesday last week, I am back to do mine.

Now, I am familiar with bureaucracy, and I have seen my share of government workers that are professionally, "less than anxious". Although, others could have had an experience different than mine, I can say that if all case workers were as prompt and professional as mine, nothing more could be expected.

My Name is Cocaine

My name is Cocaine, call me Crack for short
I entered this country without a passport

Ever since then I've made scum from the rich
Some have been murdered and found in a ditch

I am more valued than diamonds, more treasured than gold
Use me just once and you too will be sold

I'll make a school boy forget all his books
I'll make a beauty queen forget her good looks

I'll take a renowned speaker and make him a bore
I'll take your own mother and make her a whore

I'll make a school teacher forget how to teach,
and I'll make a preacher not want to preach

I'll take your rent money and get you evicted
I'll murder your babies, or they'll be born addicted

I'll make you rob, and steal and kill
When you are under my power, you will have no will

Remember my friend, my name is "Big C"
If you try me one time, you may never be free

I have destroyed politicians, actors, and heroes
I've decreased bank accounts from millions to zeros

I'll make shooting and stabbing a common affair
Once I take charge you won't have a prayer

Now that you know me what will you do?
You'll have to decide, it's all up to you

The day you decide to sit in my saddle,
the decision is one that no one can straddle

Listen to me, and please listen well
When you ride with cocaine, you ride straight into Hell

Mr. HORN. The gentlewoman from Illinois, the vice chairman of the subcommittee, will start the questioning.

Mrs. BIGGERT. Mr. Fairbanks, about how long did it take you to resolve your case, then?

Mr. FAIRBANKS. Everything was resolved on an ongoing, an as-needed basis, and there was never any—I had constant contact with my caseworker throughout each operation and each new phase, and so there was never anything that was unresolved.

Mrs. BIGGERT. Was it in a reasonable amount of time, then, as you moved along? I'm wondering if it was before anything started. Did you have to wait a long time?

Mr. FAIRBANKS. No, no, there were no waits. And during a large percentage of the time I was helpless and drugged up and incapacitated in the hospital. But, nevertheless, everything was always taken care of immediately; and there were no worries that my family or friends or the other agents that were helping me had.

Mrs. BIGGERT. And, Ms. McGuinness, did you find the same prompt service?

Ms. MCGUINNESS. No, ma'am, I did not. There were always delays. I couldn't get materials that I needed. If I needed assistance or I had a question, if I needed a copy of my file, it was denied all the way through.

Mrs. BIGGERT. Do you know other people that felt the same way?

Ms. MCGUINNESS. Yes. Yes, I do. A lot of people.

Mrs. BIGGERT. And Mr. Chamberlin?

Mr. CHAMBERLIN. It took 10 months to get the file just accepted for review, and it was a letter to the Secretary of Labor. And then, following that, it has been approximately 5 years; and the case remains pending.

Mrs. BIGGERT. Was there a problem with having correct forms in your package? Was that a part of the delay, that you didn't fill out the forms correctly or the right forms?

Mr. CHAMBERLIN. No, it appeared that OWCP personnel just did not review the entire package. And, additionally, I had a number of doctors as well as the accompanying FBI documents that I was able to obtain submitted. However, the OWCP personnel would continuously almost misinterpret, be it intentionally or inadvertently, what the doctors were saying.

The reports were there, and I would continue to submit it. And on one occasion, Mr. Israel, the claims examiner, had indicated that he was going to speak to Gloria Watson in regards to the fact he felt the entire facts were submitted for the case and the claim should be accepted, but nothing came to it.

Mrs. BIGGERT. So did the FBI fulfill their end of the bargain and did they complete the forms properly that had to go for the workers' comp?

Mr. CHAMBERLIN. Absolutely not.

Mrs. BIGGERT. And do you know why?

Mr. CHAMBERLIN. No, I'm unable to provide an explanation.

Mrs. BIGGERT. So did the Office of Workers' Compensation Programs ever ask the FBI for these forms?

Mr. CHAMBERLIN. They did back in August of, I believe it was 1996; and said they submitted the minimum amount of documents. I have been attempting to obtain, as I indicated previously, 5 years

to obtain the documents in regards to the allegations of me being homicidal, suicidal, and all the documentation surrounding it, and the FBI refuses to produce it.

Mrs. BIGGERT. Was this the Mendernach homicidal-suicide memo?

Mr. CHAMBERLIN. That is one of the documents, yes.

Mrs. BIGGERT. So the Office of Workers' Compensation Programs, were they willing to pursue these documents from the FBI?

Mr. CHAMBERLIN. No. In a FOIA request to OWCP, I had asked if they had any additional documents, other than the ones I had received from the FBI; and OWCP's position was, we have not communicated with the FBI nor do we intend to nor is there a need.

Mrs. BIGGERT. And you got help from a Congressman?

Mr. CHAMBERLIN. Yes, Congressman Price.

Mrs. BIGGERT. And so he helped you obtain that document.

Mr. CHAMBERLIN. Yes. He had submitted several inquiries on it and asking for specifically that document. And on their first release, they had provided a document to Congressman Price that was nonrelated, but it was written by Karen Mendernach on that same date, and that was just an action of their intentional deceit.

Mrs. BIGGERT. What then was the reaction of the Office of Workers' Compensation Programs to supplying the document for the case file?

Mr. CHAMBERLIN. Following the submission of the——

Mrs. BIGGERT. Yes.

Mr. CHAMBERLIN. The first time I had submitted it, which was last August and September, the report from OWCP completely ignored it. They did not address it and did not acknowledge receiving it. I had sent it to them, I had faxed it to them, and they had acknowledged receiving the fax. And I followed it up within the next 5 weeks with communications asking that it be forwarded to the appropriate claims examiner to ensure that they had it.

On the decision by Ms. Preuit, they just did not address it. It is currently before them right now, and it is 128 days pending the reconsideration.

Mrs. BIGGERT. But they have acknowledged the memo?

Mr. CHAMBERLIN. They have acknowledged receipt of the memo at the time I faxed it. They have not acknowledged the memo in their memorandum to the Director on the denial of the reconsideration.

Mrs. BIGGERT. And you mentioned in your testimony that you are on your fourth reconsideration now?

Mr. CHAMBERLIN. Yes.

Mrs. BIGGERT. And how long have you been waiting for a response to that?

Mr. CHAMBERLIN. 128 days.

Mrs. BIGGERT. Did the workers' comp group issue a date in which they stated the decision on your claim would be provided?

Mr. CHAMBERLIN. They have indicated that it would be in 90 days.

Mrs. BIGGERT. You also stated in your testimony that you struggled to confirm your appeal right from OWCP. Why was this difficult to do?

Mr. CHAMBERLIN. Well, I had received the last, and now Ms. Preuit's letter specifically stated to take it to ECAB. Following that, I had inquired if I had the right to file a reconsideration. Specifically, I did not want to go to ECAB without the homicidal-suicidal memo as part of the package. Included in the letter was for me to contact, if I had any questions, a Ms. Stone in Washington, DC, with OWCP. Her response was to just follow the appeals rights. She would not address if I did have the right to file a reconsideration.

Following that, I talked with Sheila Williams. She informed me that was an interesting question and she would have to do research to find out if I would have the right for a reconsideration. She informed me that she would be traveling the week of, I believe it was November 16th, and that she would get back with me, and she had never followed up a return call.

Mrs. BIGGERT. So she just thought that was an interesting question and that is as far as it went?

Mr. CHAMBERLIN. Yeah. She did not have the answer if I had the right to file a reconsideration.

Mrs. BIGGERT. So, has this process been financially draining to you?

Mr. CHAMBERLIN. Well, at the time I was dismissed from the FBI I lost my house. My wife had a stroke. We've had four different residences since. We have been moving around. We've lived in two abandoned farmhouses and just fixed them up.

I have applied for several hundred jobs, over 60 in the State of North Carolina. I have two master's degrees, course work completed for a Ph.D., and 25 years of government experience and applying for a job of \$22,000 and up, and I have been unable to obtain full-time, permanent employment.

Mrs. BIGGERT. So do you have a source of income?

Mr. CHAMBERLIN. I have retirement now from the OPM.

Mrs. BIGGERT. Thank you very much.

Thank you, Mr. Chairman.

Mr. HORN. Well, thank you.

Mrs. Williams was mentioned, and you said she did not get back to you. Was she cooperative when she talked on the telephone?

Mr. CHAMBERLIN. Sir, I guess it could be—I wouldn't want to make a biased statement to say that she was uncooperative or she was passive. She just felt it was an interesting question; she would have to do the research.

And then I still had not had the answer, and I had checked with Congressman Price's office and she was very concerned, Ms. Gay Eddy, of whether I should file—she was emphasizing to file with ECAB because of the 90-day restriction for ECAB. And then I had submitted it within the 90-day period, and if that wouldn't suffice I was going to go to ECAB.

When I submitted it, I followed it up with a phone call. And Ms. Williams stated, well, we have it; I guess it will go. She did not elaborate.

Mr. HORN. Do you remember what her position was in the Department of Labor?

Mr. CHAMBERLIN. I believe she is the Deputy Director, or was the Deputy Director.

Mr. HORN. For the region or a district or what?

Mr. CHAMBERLIN. I was under the impression for the entire OWCP.

Mr. HORN. I see. So she is in Washington, not in the field?

Mr. CHAMBERLIN. Correct.

Mr. HORN. What was the region that you dealt with on most of your activity and claims?

Mr. CHAMBERLIN. When I initiated the claim, I was told to file with Jacksonville, FL; and I began to make the filings with Jacksonville, FL. And, unbeknownst to me, as the time progressed, this is where they had sent the files to the FBI and had returned the packages on two occasions saying they were not processing the claim.

Following that, I submitted the letter to the Secretary of Labor, Honorable Robert Reich. And as a result of submitting it to him, I'm making the assumption he had forwarded it to the Washington, DC, office. I believe it was the security office, OL 9. So OL 9 actually processed the claim.

Mr. HORN. So you were working with the Florida region, I assume?

Mr. CHAMBERLIN. Initially, yes.

Mr. HORN. But also with the national headquarters?

Mr. CHAMBERLIN. Yes. Somehow, in other words, in trying to get the claim filed initially with OWCP, it was with the Jacksonville, FL, office. And then, as a result of the Secretary of Labor's actions, it was submitted to Washington, DC.

Mr. HORN. Did the OWCP pursue the missing documents from the FBI?

Mr. CHAMBERLIN. They were not of any assistance at all. They specifically told me that they had sufficient documents from the FBI and that they had no need to further communicate with the FBI nor did the FBI have a need to communicate with them.

Mr. HORN. So they had seen or had held the documents. It is just you that didn't see them.

Mr. CHAMBERLIN. No, they said they never received—or they had no acknowledgment. The documents that they had provided me under the FOIA, of the documents that were submitted to OWCP by the FBI, were very limited, approximately 20 pages.

Mr. HORN. Ms. McGuinness, what region was it primarily with whom you dealt?

Ms. MCGUINNESS. New York region.

Mr. HORN. The New York.

How about you, Mr. Fairbanks? What was your region that was helping you on the case?

Mr. FAIRBANKS. The Dallas, TX, region.

Mr. HORN. Dallas, TX, region.

Well, thank you. Are there any other points you would like to make?

I think you have a very full record here. And we, I might say, out of the three of you, we have hundreds of files that have been sent to us over the last few months; and some of them are just very tragic and similar to some of your cases in terms of the lack of, shall we say, proper handling in the sense, I don't want to use the word handling particularly, but just that people on the government

payroll ought to realize that they are there to serve the people; the people are not there to serve them. And it comes up again and again in office after office that we have real problems with in that area.

I'm glad to hear Mr. Fairbanks had a very positive experience. That hasn't been the tenor of a lot of the files that have come in from all over the country, and that's what started me on this in Long Beach about 3 years ago when I had 60 people under the Federal injured workers situation. And I just went right down the line and I said, tell me your story; and I came back filled with 60 stories, most of which either the government agency or this program had been less than helpful, to put it charitably.

So I thank you for getting this on the record, and we appreciate it, and thank you very much for coming.

We will now start with panel II, if they will come forward.

Beth Balen, administrator of the Anchorage Fracture and Orthopedic Clinic; John Riordan is first vice-president, Council 220 of the American Federation of Government Employees; James Linehan is an attorney; and Tina Maggio is field representative for the Office of Representative Michael F. Doyle.

If you would stand and raise your right hands, please.

[Witnesses affirmed.]

Mr. HORN. The clerk will note all four witnesses have affirmed the oath.

We will begin with Beth Balen. Thank you for coming all that distance, Ms. Balen.

STATEMENTS OF BETH BALEN, ADMINISTRATOR, ANCHORAGE FRACTURE AND ORTHOPEDIC CLINIC; JOHN RIORDAN, FIRST VICE-PRESIDENT, COUNCIL 220, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; JAMES LINEHAN, LAWYER, JAMES R. LINEHAN, P.C.; AND TINA MAGGIO, FIELD REPRESENTATIVE, OFFICE OF REPRESENTATIVE MICHAEL F. DOYLE

Ms. BALEN. Thank you. My name is Beth Balen, and I'm the administrator of the Anchorage Fracture and Orthopedic Clinic, which is an eight-physician orthopedic group in Anchorage, AK. I would like to, I guess, apologize for the length of my statement that I submitted. Unfortunately, most of it is numbers, so there's a lot of backup documentation there.

Federal workers' compensation claims, paid through the U.S. Department of Labor, have been a long-term problem for our clinic and other Alaska providers in general, and these difficulties have led many offices in the State to refuse to accept USDOL patients.

Our physicians want to be able to treat sick and injured patients, but it's difficult to deal with all the USDOL guidelines which, really, the government relationship or the government regulations are interfering with the doctor-patient relationship. They're sort of getting right smack in the middle of it.

In the past 3 years, our office as well has pretty much stopped accepting appointments from USDOL patients due to the low reimbursement rates and the amount of staff time involved to obtain payment. We will see the patient, but frequently we make them self-pay, particularly if a case number has not been issued yet, be-

cause we don't have time to deal with the headaches of billing the USDOL.

And I would like to stress that this doesn't apply if the patient comes to us from the emergency room when we are on trauma call for the city, in which case we take any and all patients and whatever insurance coverage they may or may not have.

The problems that we experience with U.S. Department of Labor patients include, No. 1, the low fee schedule. I have included a number of examples in my statement which show the actual patient bills for some of our recent USDOL patients, starting on page 3 in my statement. I have shown you our charge, the amount Alaska Workers' Compensation would have paid if it had been State workers' comp, and the amount the USDOL actually paid.

For example, a carpal tunnel release that we charge \$1,428 for, Alaska Workers' Comp actually allows more than we charge. They allow \$1,733, but the USDOL paid \$691. For a laminotomy, back surgery, we charge \$5,227. Alaska Workers' Comp pays \$4,608. USDOL paid \$2,107. Frequently, it's less than 50 percent of the charge. We end up writing off considerably more than we get paid.

The second major issue that we have a problem with are the forms. The forms that a USDOL patient comes in with are lengthy, they are time consuming, and in the amount of time it takes a physician to complete his part of the form he could have seen another patient. The forms are also redundant, because the information that they request is standard in medical office visit dictation, which is always attached to the claim anyway.

From 1988 through 1991, our office didn't see any USDOL patients, which was following a sting operation engineered by the U.S. Department of Labor which targeted Alaska physician offices. In 1991, we started seeing these patients again, after we worked out an arrangement with the USDOL in Seattle that we would bill with our chart notes and our standard forms and not use the lengthy forms, which we continue to do today, but we're constantly hounded by the patients and their employers that the form has to be filled out.

Another problem is the delay that we have as the patient obtains their case numbers. Our experience has shown it takes at least 30 to 45 days for a claim number to be issued by the USDOL, and there is absolutely no way in the meantime to bill a claim to the USDOL without a case number on the bill. It's returned immediately to our office saying there's no case number on file.

It doesn't appear that there's any way for the USDOL to enter the claim in their computer and wait for a claim number to be issued, and it also doesn't appear that they are willing or able, one of the two, to put in a patient's name and look and see if there's a case number on file. They won't look it up.

Many times we have a claim number, we have it written on the bill, and the claim still gets rejected for no claim number. It looks to us, although we have no way to prove this, that it's possible for a claim number to exist in one part of the USDOL's computer but not in another part, namely the claim payment portion.

Frequently, claim numbers are issued without the proper medical condition attached to them, then the claim gets denied, saying that the billed services are not related to the accepted condition. If the

claim gets rebilled three or four times with no changes made to it, eventually it gets paid because something gets updated in the computer. So rebillings are just a constant—it is almost a given with the U.S. Department of Labor. You do not get paid the first time you submit the bill. You have to do it several times.

There seems to be very poor communication between Federal employers and the USDOL, and I question whether this is because the employers are not properly instructed in the process or whether the process is just so complicated that nobody could possibly follow it. And I have given you an example of this attached, which almost seems like it belonged in the testimony for the first panel, where this employer authorized the claim and the USDOL issued paperwork but it took more than 8 months from the date of this patient's surgery plus hours of staff time to get the claim paid.

The automated telephone system presents a problem. It's not possible to call and speak to a person if you are having problems with the claim. You punch numbers, you leave a message, the message process that you have to follow to get information or leave a message is very long, and you never know if you are going to get a call back or not. Although I must say that recently we did get a call back on a claim. I don't know if that's a fluke or a sign of improvement.

The time involved to work these accounts in order to receive payments has become a serious issue to us, and typically the amounts of reimbursement we get is not worth the effort.

The Federal Government is the largest employer in Alaska. Many of our friends and relatives work for them. My husband works for them. Our doctors want to be able to treat all of the sick and injured patients that need it and come to us, but the USDOL rules make it virtually impossible to do so. The combination of low reimbursements rates, the difficulties we have had in obtaining payment, and the past history we've had in dealing with USDOL just doesn't make treating USDOL patients good business sense. Thank you.

[The prepared statement of Ms. Balen follows:]

Congress of the United States
House of Representatives
Committee on Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

RE: Office of Worker's Compensation Programs

Beth A. Balen, CMPE
Administrator
Anchorage Fracture and Orthopedic Clinic
3260 Providence Drive, Suite 200
Anchorage, AK 99508
907-261-7135

May 18, 1999

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RE: Office of Workers' Compensation Programs

Introduction

Federal Worker's Compensation claims, paid through the U.S. Department of Labor (USDOL), have been a long-term problem for Alaska medical providers. The difficulties encountered when dealing with this patient population have led many offices to refuse to accept USDOL patients, except under very specific circumstances. These difficulties include delays in payment, frequent rebillings, low reimbursement rates, inability to get telephone assistance, and multiple lengthy and redundant forms. Physicians want to be able to treat sick and injured patients, and they have become increasingly dissatisfied with the Federal Worker's Compensation guidelines, which have made caring for these injured workers so very difficult.

Injured Federal workers are given a variety of forms and instructed to have their physician complete them. These forms are time-consuming for the physician to fill out, and most of the information requested from the physician is already found in the standard medical office dictation that describes a worker's compensation patient visit. Examples of these forms may be found at the back of this document, pages A-1 through A-14. One of the best ways to control health care costs in a physician's office is to keep the physician productive. In the time required to complete one of these Federal Forms, the physician could have seen an additional patient.

In 1991 Anchorage Fracture & Orthopedic Clinic (AFOC) worked out an arrangement with Dr. Robert Reynolds, at the USDOL office in Seattle, whereby we would see USDOL patients, but not complete their lengthy forms. We would use our standard billing forms and work releases, submitted with our chart notes, which answer all the questions in their forms. This arrangement was part of a larger agreement for AFOC to agree to a 90-day trial of seeing Federal Worker's Compensation patients. If we were the first physicians to examine the patient, we would complete the Form CA-16 (example on page A-1), which is the report of initial injury. (Correspondence from and regarding Dr. Reynolds is included on Page B-1 and B-2.) Our office continues to complete Form CA-16 today, although we still do not fill out the other forms.

Report to Committee on Government Reform
May 18, 1999
Beth A. Balen, CMPE
Page 1

At the time the 90-day trial was set up, there were no orthopedic surgeons in the Anchorage area who were willing to see USDL patients, due to the cumbersome paperwork, and an undercover sting operation by the U.S. Department of Labor in the Fall of 1987 through the Spring of 1988. In this sting operation two agents were sent to various physician offices posing as postal worker employees with work-related injuries, with the intent of tricking the doctor into granting unnecessary time off from work. The agents wore wires, and recorded the office visits. A news article from the Washington State Orthopedic Society newsletter from Spring, 1989 is included on pages B-3 and B-4, and gives the complete story on this sting operation. It should be noted that the Anchorage orthopedist featured in the story was a member of our group at the time. Following the sting operation our clinic, as well as most orthopedists in Anchorage, refused to see any USDL patients until the 90-day trial was attempted in 1991. USDL patients needing care had to be sent to Seattle.

In the past three years the low reimbursement rates and amount of staff time involved to obtain payment for services have led our clinic to again stop accepting appointments from USDL patients, scheduling them on a self-pay basis only. We are happy to see the patient, but we do not want to take on the headaches associated with billing USDL and the process of returning the patient back to work. Our doctors may individually choose to accept a patient with their USDL coverage if they are contacted directly by another physician.

The only exception to this rule is when we are the assigned orthopedic trauma call physicians for the city, covering the hospital emergency rooms. In this situation we accept any and all patients, along with whatever insurance coverage they have, if they are either seen by our physician in the emergency room, or referred to our office for follow-up after treatment in the E.R. by any E.R. physician.

Details of Problems Experienced with USDL Patients

1. Low Fee Schedules

The fee schedule from which the USDL pays is extremely low, as shown in the examples, which follow. Details of these actual patient charges and payments are found in the appendix, as referenced by page number below. Detailed is the Surgical CPT code, a brief description of the procedure, our charge for that particular code, USDL's actual payment, and the amount written off. As demonstrated, the amount written off is frequently higher than the amount actually paid for the service. Also included are the maximum allowed amounts for each procedure per the State of Alaska Worker's Compensation fee schedule, and the average commercial insurance allowable for the area, based on the Medicode Fee Analyzers for our specific area (this schedule also shows the average charge for our geographic locale).

Code	Description	AFOC Charge	Alaska W/C Allowed	Commercial Indemnity Allowable	USDL Paid	Write-off	Page reference
64721	Carpal Tunnel Release	\$1428.00	\$1733.14	\$1545-1694	\$691.00	\$737.00	C1-3, D18, E6
99212	Established Patient Office Visit	\$52.00	\$66.74	\$56-64	\$46.00	\$6.00	C4-5, D21, E8
63030-20	Laminotomy	\$5227.50	\$4608.51	\$3993-4094	\$2102.00	\$3125.50	C4-5, D17, E9
72100	Lumbar X-Rays	\$108.00	\$133.32	\$100-121	\$48.00	\$60.00	C4-5, D19, E10
99204	New Patient Office Visit	\$197.00	\$183.44	\$159-182	\$172.00	\$25.00	C6-7, D21, E11
63030-80	Laminotomy Asst. Surgeon (25%)	\$1045.50	\$1152.13	\$1106-1190	\$415.00	\$630.50	C6-8, D17, E12
22554	Neck Spine Fusion	\$4345.00	\$5156.36	\$4381-4655	\$3085.00	\$1260.00	C9-10, D12, E13
63075-51	Discectomy (50%)	\$2171.50	\$2379.56	\$2285-2457	\$1471.00	\$700.50	C9-10, D17, E14
20936	Autograft for Spine Surgery	\$580.00	\$616.34	\$578-675	\$580.00	\$0	C9-10, D11, E15
63047	Laminectomy, Single Segment, L3	\$5075.00	\$5572.39	\$4634-5159	\$2427.00	\$2648.00	C11-12, D17, E16
63048	Laminectomy, Addl. Segment, L4	\$1600.00	\$1807.26	\$1503-1673	\$609.00	\$991.00	C11-13, D17, E16
22612-51	Arthrodesis, Post/Post-lat, L4-5 (50%)	\$2316.50	\$2333.94	\$1672-2071	\$1553.00	\$763.50	C11-12, D12, E17
22614	Arthrodesis, Post/Post-lat, L5-S1	\$1366.00	\$1555.96	\$1115-1381	\$912.00	\$454.00	C11-13, D13, E17
20975-51	Electrical Bone Stimulator	\$375.00	\$727.24	\$1042-1169	\$231.00	\$344.00	C-11,13, D11, E18
26055	Tenodesis, Finger	\$791.00	\$1033.97	\$737-842	\$455.00	\$336.00	C15-16, D16, E19
23420	Repair, Shoulder Clavicle Avulsion	\$3264.00	\$3826.97	\$3343-3531	\$2099.00	\$1165.00	C17-18, D14, E20
25620	Colles Fracture	\$1758.00	\$1725.46	\$1424-1562	\$1154.00	\$404.00	C19-20, D15, E21
73110	Wrist X-Rays	\$86.00	\$114.25	\$85-98	\$48.00	\$38.00	C19-20, D20, E22

2. Delays in obtaining Case Numbers

Past experience and the information available to us lead us to conclude that it takes at least 30 to 45 days for a Case Number to be issued to an injured Federal worker. Since a claim cannot be submitted without a Case Number, there is a delay in the billing if the patient has either not yet received a number, or not given it to the physician. Once the number has been given to the patient, they may not think to call the physician and provide them with that information, perhaps because they are not informed of what a critical piece of information it is.

There is no way to bill a claim to the USDL without a Case Number. Billings sent without a Case Number are returned immediately with a denial stating there is no valid claim number on file. The provider of service has no way of knowing if there is actually no Case Number on file, or if the provider just does not have the information. The USDL payment office is either unable or unwilling to do a name search to determine if there is a Case Number in existence for that patient.

3. Rebilling of claims

Rebilling of medical claims is time-consuming and is frequently necessary before payment can be obtained from USDL. As mentioned above, the claim may be returned for no Case Number. However, many times we have had a Case Number and had it written on the bill, only to have the claim rejected for no claim number! It appears that it is possible for a claim number to exist in one part of the USDL computer without being cross-referenced to the claim payment system.

Denials are also received due to the diagnosis on the medical billing not matching the diagnosis attached to the Case Number (see page F-19). Denials are frequently received which say "Billed services not related to the accepted conditions in this claim." If the claim is rebilled three to four times, without any changes, it will eventually get paid, as the claim number finally gets updated with the correct medical information. An example of this is described in the situation detailed below.

There seems to be poor communication between Federal employers and employees and the USDL. I question whether this is due to employers and employees not being properly instructed in the entire process, or whether the process itself is so complicated that it is difficult for even the most diligent, well-trained person to complete it correctly.

An example of this is the medical claim beginning on page F-1. In this claim the employer authorized the work-related condition (see page F-6), and the USDL issued paperwork with a claim number, but it still took eight months from the date of surgery, plus hours of staff time, for our office to receive payment for the surgery charges. This patient, who is an FBI

employee, was injured on April 13, 1996, and was seen in the emergency room in Fort Smith, Arkansas. He consulted in our office on August 5, 1996, but did not indicate that this was a work-related condition. The patient completed the appropriate USDL forms on August 12, 1996 (see page F-3), and notified our office on August 13, 1996 that this was a work-related condition, and that we were to send the bills directly to his employer at the FBI office in Anchorage. With our knowledge of the difficulties in dealing with the USDL this seemed like an effective alternative for handling the billing. We received notification from USDL dated September 23, 1996 that the claim had been accepted, and a case number assigned (page F-5).

Meanwhile the patient had required surgery for his back, which was performed on August 27. Although authorization for surgery had not yet been received from USDL, the patient's employer assured us that, as long as our physician felt the surgery was medically necessary and needed to be done without delay, we should proceed, and authorization could be obtained retroactively. This began a series of denials and rebillings. We were working with the local FBI office, who was assuring us that this was a valid claim and would be paid, but all the while we were receiving denials and rejections on the surgery claim from the USDL. Although they were paying the physical therapy and doctor visits for the patient's back condition, they were denying the patient's back surgery because it was not related to the condition accepted for his claim (see denial notice on page F-19).

Complete documentation of this situation is found on pages F-1 through F-21. These types of machinations are not unusual when working with USDL, and demonstrate the amount of staff and physician time required in resolving an unpaid claim. It always appears that the right hand does not know what the left hand is doing at the USDL, and in this particular example resulted in the major part of our charges not being paid until April 21, 1997, eight months after the services were performed. We received the check on April 29. Payment on a \$4,100 charge was only \$2,102, 45.6% of the Alaska Worker's Comp allowable, and 49.3% of the commercial indemnity allowable for our area.

4. Automated telephone system

When calling the USDL it is not possible to call and speak to a person. The caller punches numbers and leaves a message. The message process that must be followed to get information or leave a message for a call back is very long, and there is no way to bypass the message (such as pushing "0" for an operator) and reach a person. Recent experience has shown an improvement in the timeliness of call-backs, but the process is frustrating, particularly when a doctor is waiting for information, or a patient is in the office, waiting for help.

At one point we had a contact in the USDL office who we could reach directly, and who was very helpful, but she no longer works there.

Conclusion

In conclusion, in order to adequately assist injured federal workers, while making it a worthwhile business decision to treat them, we need the following:

1. Higher fee schedules, which should have geographic adjustments to account for different price ranges in various parts of the country (similar to Medicare's GPCIs), and which match, or nearly match, the state Worker's Compensation fee schedules.
2. Easier access to the claim payment office.
3. Less paperwork for the patient, employer and physician to complete, which would speed up the entire process and make it less prone to error.
4. Overall simplification of the process, by reducing the length and number of forms, the authorization process whereby a condition is accepted as work-related, and improvement in access to the claims office. There may be states with Worker's Compensation systems which work well, and might be used as a model.

Approximately 20% of the patients in our clinic are Worker's Compensation (mostly state of Alaska worker's comp), 17% are Medicare, 5% are Medicaid, and about 5% are self-pay. Obviously we are accustomed to State and Federal regulations and compliance issues, and are also willing to treat patients who may not have top-notch insurance benefits. Our physicians want to be able to treat sick and injured patients, but the USDL rules make it virtually impossible to do so. The Federal Government is the largest employer in Alaska (see page G-1 and G-2), and many of our friends and relatives work for them. However, due to the combination of low reimbursement rates, the past history in dealing with the OWC, and the difficulties in receiving payment, treating USDL patients makes poor business and medical sense.

Sincerely,



Beth A. Balen, CMPE
Administrator
Anchorage Fracture & Orthopedic Clinic
907-261-7135

Authorization for Examination
And/Or Treatment

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



The following request for information is authorized by law (5 USC 552(a)(2)). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and is requested. Information collected will be handled and stored in compliance with the Freedom of Information Privacy Act of 1974 and OMB Circular No. A-108.

OMB No.: 1215-0103
Expires: 09-30-91

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:

2. Employee's Name (last, first, middle)

3. Date of Injury (mo., day, yr.)

4. Occupation

5. Description of Injury or Disease:

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 3, subject to the condition stated in item A, and to the condition indicated either 1 or 2, in item B.

- A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.
- B. ☐ 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.
- ☐ 2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be to the injury or to the employment.

3. Disease or illness is involved, OWCP Approval for Issuing Authorization was Obtained from: (Type Name and Title of OWCP Official)

4. Signature of Authorizing Official:

5. Name and Title of Authorizing Official: (Type or Print Clearly)

10. Local Employing Agency Telephone Number:

11. Date (mo., day, year)

12. Send one copy of your report: (Fill in remainder of address)

13. Name and Address of Employee's Place of Employment:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

Department of Agency

Bureau or Office

Local Address (including Zip Code)

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing burden, to the Office of Information Management, Department of Labor, Room N-301, 200 Constitution Avenue, N.W., Washington, D.C. 20210, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Form CA-16
Rev. Oct. 1988

A-1

PART B - AT		(G) PHYSICIAN'S REPORT	
14. Employee's Name (last, first, middle)			
15. What History of Injury or Disease Did Employee Give You?			
16. Is there any history or evidence of Concurrent or Pre-existing injury, disease, or physical impairment? (if yes, please describe)		16a. ICD-9 Code	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
17. What are Your Findings? (include results of X-rays, laboratory tests, etc.)		18. What is your diagnosis?	
		18a. ICD-9 Code	
19. Do You Believe the Condition Found was Caused or Aggravated by the Employment Activity Described? (Please explain your answer if there is doubt)			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
20. Did Injury Require Hospitalization?		21. Is Additional Hospitalization Required?	
if yes, date of admission (mo., day, year)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of discharge (mo., day, year)			
22. Surgery (if any, describe type)		23. Date Surgery Performed (mo., day, year)	
24. What (Other) Type of Treatment Did You Provide?		25. What Permanent Effects, if Any, Do You Anticipate?	
26. Date of First Examination (mo., day, year)		27. Date(s) of Treatment (mo., day, year)	
		28. Date of Discharge from Treatment (mo., day, year)	
29. Period of Disability (mo., day, year) (if termination date unknown, so indicate)		30. Is Employee Able to Resume	
Total Disability: From To		<input type="checkbox"/> Light Work Date:	
Partial Disability: From To		<input type="checkbox"/> Regular Work Date:	
31. If Employee is Able to Resume Work, Has He/She been Advised?		<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Furnish Date Advised	
32. If Employee is Able to Resume Only Light Work, indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.			
33. General Remarks and Recommendations for Future Care, if indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.			
34. Do You Specialize? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, state specialty)			
35. SIGNATURE OF PHYSICIAN. I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.		36. Address (No., Street, City, State, Zip Code)	
		37. Tax Identification Number	
		38. Date of Report	

MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim Form" (AMA CP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

INSTRUCTIONS FOR AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

SELECTION OF
PHYSICIAN

- A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 issued to either a United States medical officer/hospital or any duly qualified physician/hospital of the employee's choice.

If the employee elects to be treated by a private physician, a copy of the American Medical Association standard billing form (AMA OP 407/408/409; OWCP-1500a) should be supplied together with Form CA-16.

A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee.

Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

PERIOD OF
AUTHORIZATION

- Form CA-16 is valid for up to sixty days from date of issuance, and may be terminated earlier upon written notice from OWCP to the provider. It should not be used to authorize a change of physicians after the initial choice is exercised by the employee.

FEDERAL MEDICAL
FACILITIES

- U.S. medical facilities include Public Health Service, Military, or VA hospitals. Federal health service facilities (health units) established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.400).

DEFINITION
OF INJURY

- The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which required medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP.

DEFINITION OF
PHYSICIAN

- The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination, related laboratory tests and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

FORM
COMPLETION

- Part A shall be completed in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in item 1 and the signature of the authorizing official appears in item 8. Check B1 or B2 or item 6, whichever is appropriate. In case of illness or disease, only Box B2 may be checked.

Show the address of the proper OWCP Office in item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

ADDITIONAL
INFORMATION

- See 20 CFR and/or Chapter 810, Federal Personnel Manual (FPM)

Information for Physi

see Reverse Side

Form CA-16

A-3

INFORMATION FOR PHYSICIAN

YOUR
AUTHORIZATION

- Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in item 5, for a period of not more than 60 days from the date of issuance, subject to the conditions in item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated earlier upon written notice from OWCP. For extension of the authorization to treat beyond the 60 day period, apply to the office shown in Part A, item 12.

USE OF CONSULTANTS
AND HOSPITALS

- You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accommodations unless a private room is medically necessary. Ancillary treatment may be provided to a hospitalized employee as necessary.

REPORTS

- After examination, complete items 14 through 38, of Part B, and send your report, together with any additional narrative or explanatory material, to the address listed in Part A, item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA 17, "Duty Status Report" may be required by the employing agency during the first 45 days of disability. If disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are also required. Delay in submitting medical reports may delay payment of benefits.

RELEASE OF
RECORDS

- Injury reports are the official records of OWCP. They shall not be released to anyone nor may any other use be made of them without the approval of OWCP.

BILLING FOR
SERVICES

- OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500, or HCFA-1500). Each procedure must be identified, in Column 24 C of the form, by the applicable Current Procedural Terminology (4th edition) Code CPT 4). A copy of the form may be supplied by the employee at the time treatment is sought.
- Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

TAX IDENTIFICATION
NUMBER

- The provider's Tax Identification Number (TIN) is an important identifier in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. If possible, providers should decide on a single TIN - either corporate or personal - which is used consistently on OWCP claims.

ADDITIONAL
INFORMATION

- Contact the OWCP shown in item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report.

A-4

Form CA-16

Claim for Continuing Compensation on Account of Disability		U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs	
Statement of Injured Employee - See Instructions on Reverse Side		OMB No. 1215-0103 Expires 4-09-86	
1. Name of Injured Employee (Last, first, middle)		2. OWCP File Number (if known)	
3. Home Mailing Address (include zip code)		4. Social Security Number	
5. Date and Hour of Injury (Mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM		6. Period Compensation is Claimed As a Result of Pay Loss (Mo., day, year) If pay loss was intermittent attach separate sheet showing dates and hours of pay loss. From: To:	
7. Have you received any leave pay during the period shown in item 6? <input type="checkbox"/> Yes <input type="checkbox"/> No Show Inclusive Dates. From: Through: If leave was intermittent, attach separate sheet showing dates and hours used.		8. Do you wish to repurchase leave? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Complete this item if you worked anywhere during the period shown in item 6. Attach a separate sheet if needed.			
a. Salaried Employment.			
Dates & Hours Worked:	Pay Rate (Per hour, day or week)	Total Amount Earned	Type Work Performed
b. Commission and Self-Employment. Show all activities, whether or not income resulted from your efforts.			
Dates & Hours Worked:	Name and Address of Business	Self-Employed <input type="checkbox"/> Commission <input type="checkbox"/>	Type of Activity Performed
			Income Earned (Amount Explanation if needed)
10. If you were only partially disabled and did not work, state reason for not working.			
11. If, since filing your initial claim for compensation, you have applied for or received VA Benefits based on Military Service for the United States, give the following:			
Claim No.	Date of Disability and Monthly Payment	Name and Address of Office Where Claim is Filed	
12. If, since filing your initial claim for compensation, you have applied for or received an annuity under the Civil Service Retirement Act or other Federal retirement or disability law, give the following:			
Claim No.	Amount of Monthly Payment	Name and Address of Office Where Claim is Filed	
13. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF			
Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.			
For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20540			

Statement of Official Superior

1. Employee's name (last, first, middle initial) _____
 2. Employee's position _____
 3. Employee's date and hour of injury (month, day, year, AM/PM) _____
 4. Show employee's work week on return to duty, if other than Monday thru Friday. (Month, day, year, AM/PM) _____

5. Has employee received any pay for work, leave, subsistence, quarters or other allowances from your agency during the period shown in item 3 on the reverse side of this form? ☐ Yes ☐ No

6. If answer to item 5 is Yes, show: Amount: \$ _____ Type of Payment: _____

7. If there has been any change in employee's health, dental enrollment and/or optional insurance since previous claim for compensation was submitted, please explain. (If a change of plan or options if additional deductions have been made by the agency, show amount and period.) _____

8. Remarks _____

9. Signature of Official Superior _____ 23. Title _____ 24. Date (mo., day, year) _____

Instructions for Injured Employee

a. Items 1 through 14 on the reverse side should be completed by the injured employee or by someone acting on the employee's behalf. The form should then be given to the official superior.

b. The injured employee should file Form CA-6 each two weeks during the period of disability unless otherwise notified by OWCP. Forms may be obtained from OWCP or the employing agency.

c. Employees are advised that fraudulent claims are punishable by a fine of not more than \$10,000, or imprisonment for not more than five years, or both.

d. The employee is responsible for submitting, or arranging for the submission of medical evidence in support of this claim. The CA-20a is attached to form CA-6 for this purpose. The employee should complete items 1 - 6 on form CA-20a. The attending physician should complete items 7 through 23. The address of the appropriate OWCP office should be entered in item 5 on the reverse of the CA-20a.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department of Labor, Office of IRM Policy, Room N1301 (1215-0103), 200 Constitution Avenue, NW, Washington, D.C. 20510.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

Attending Physician's Supplemental Report		U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs	
For Instructions See Reverse Side		OMB No. 1215-0103 Expires 10-31-83	
1. Name of injured employee (Last, first, middle)		2. OWCP File Number, if known	
3. Home mailing address (include Zip code)		4. Social Security Number	
5. Date and hour of injury (Mo., day, year)		6. Period compensation is claimed as a result of pay loss (Mo., day, year)	
7. Date of most recent examination (Mo., day, year)		8. Is employee's present condition due to the injury for which compensation is claimed?	
9. Is employee totally disabled for work?		10. Describe nature of present impairment	
11. Date diagnosis		12. ICD-9 Code	
13. What treatment is employee receiving and how often is it given?			
14. What permanent effects, if any, are anticipated?			
15. Will disability for regular work continue for 90 days or longer?			
16. If employee is able to resume regular work, has he or she been advised?			
17. If employee is only partially disabled, show date he or she was able to perform some work and describe specific work restrictions.			
18. If employee has been referred to another physician for consultation or treatment, give physician's name & address.			
19. Recommendations and Prognosis			
20. Address (include Zip code)			
21. Date of Report (Mo., day, year)			
22. Signature of Physician. I certify that the statements on the reverse: apply to this report and are made a part hereof.			
<p>Public Burden Statement</p> <p>We estimate that it will take an average of 30 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Management Policy, U.S. Department of Labor, Room N1301 (1215-0103), 200 Constitution Avenue, NW, Washington, D.C. 20210.</p> <p>DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE. Please do not respond to this collection of information unless it displays a currently valid OMB control number.</p>			

INSTRUCTIONS FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

CERTIFICATION: BY SIGNING BLOCK 22 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-20a ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPRESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION CAN BE MADE TO THE EMPLOYEE.

IF YOU HAVE SUBMITTED A MEDICAL REPORT ON FORM CA-16, CA20 OR A NARRATIVE REPORT TO THE OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20a.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA-1500/OWCP 1500a.

1. Complete the entries 7-22 on this report (and items 1-6 if not previously completed), and

2. Forward the report directly by mail to the OWCP office indicated below.

OFFICE OF WORKERS' COMPENSATION PROGRAMS	
Send to: Director Office of Workers' Compensation Programs U.S. Department of Labor Washington, D.C. 20340	Send to: Director Office of Workers' Compensation Programs U.S. Department of Labor Washington, D.C. 20340

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor; in accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families; (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act; (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches; (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register; (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits; (6) Disclosure of a social security number (SSN) is required by P.L. 103-296 106 Stat. 1464. Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefit and payment files.

Form CA-20a

U.S. GOVERNMENT PRINTING OFFICE: 1994-548-534

**Claim for Compensation
On Account of Traumatic Injury
or Occupational Disease**

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



Employee Statement		OMB No. 1215-0103 Expires: 10-31-99	
1. Name of Employee Last First Middle		2. OWCP File Number	
3. Social Security Number	4. Period of wage loss for which compensation is claimed From mo. day yr. Thru mo. day yr.		5. Is this a claim for a schedule award? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has any pay been received for period shown in item 4? <input type="checkbox"/> Yes <input type="checkbox"/> No	7. If yes, amount From mo. day yr. Thru mo. day yr.		
8. Complete this item if you worked during the period shown in item 6. Attach a separate sheet if needed.			
a. Salaried Employment: Dates & Hours Worked Pay Rate Total Amount Earned Type Work Performed Name & Address of Employer			
b. Commission and Self-Employment. Show all activities, whether or not income resulted from your efforts. Dates & Hours Worked Name and Address of Business Self-Employed <input type="checkbox"/> Commission <input type="checkbox"/> Type of Activity Performed Income Derived (Attach Explanation if Needed)			
9. Was claim made against 3rd party? <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Name of 3rd party or insurance carrier	
11. Has the claim been settled? Give amount recovered.		Address	
		City	State ZIP
12. Have you ever applied for or received benefits from the Veterans Administration based on disability incurred while serving in the Armed Forces of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, furnish ▶		a. Claim number	b. Address of VA office where claim is filed
13. Have you applied for or received an annuity under the U.S. Civil Service Retirement Act or any other Federal Retirement or Disability Law? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, furnish ▶		a. Claim number	b. Date annuity began mo. day yr.
			c. Amount of monthly payment \$
Dependents			
14. List your dependents			
Name	Date of Birth mo day yr	Relationship	Living with you? (yes/no)
15. Support information for above dependents			
Are you making support payments for a dependent shown above? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. Were support payments ordered by a court? If so, attach copy of court order. <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. If yes, support payments are made to: Last First Middle		18. Amount \$ Per	
Street		City	State ZIP
Signature of Employee			
19. I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed, and every statement above is true to the best of my knowledge and belief.			
Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation as provided by the FECA, or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.			
Employee's signature		Date (Mo., day, year) A-9	
20. Employee's home mailing address (include Zip Code)		City State ZIP	
Street			

Statement of Official Superior				
21. Pay Rate As Of:				
Date of Injury	a. Base Pay	b. Substistence	c. Quarters	d. Other (Specify)
	\$ per	\$ per	\$ per	\$ per
Date Employee Stopped Work	\$ per	\$ per	\$ per	\$ per
If employee received additional pay, identify type and show amount				
<input type="checkbox"/> Premium Pay		per	<input type="checkbox"/> Night Pay	per
<input type="checkbox"/> Sunday Pay		per	<input type="checkbox"/> Other (identify)	per
23. Show work schedule for week pay stopped				
<input type="checkbox"/> Sun	<input type="checkbox"/> Mon	<input type="checkbox"/> Tue	<input type="checkbox"/> Wed	<input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat
25. If not, would position have afforded employment for 11 months but for the injury?			24. Did employee work in position for 11 months prior to injury?	
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
26. Total length of federal civilian service			Yrs. Mos.	
Health Benefits and Optional Life Insurance				
27. Was the employee enrolled in a Health Benefits Program at first opportunity, or for 5 years prior to the date pay stopped?			28. Was the employee enrolled in an Optional Life Insurance Program on the date pay stopped?	
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, give code			If yes, was employee enrolled in Option	
Ending date of the pay period in which HBS / OLI Deductions were last made?			<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
mo. day yr.			If Option B, show number of multiples	
Leave and Continuation of Pay				
29. Type and inclusive dates employee received leave for any part of period since stopping work. Specify type of leave, SICK, ANNUAL, or OTHER				
Type of Leave	From mo. day yr.	Thru mo. day yr.	Type of Leave	From mo. day yr. Thru mo. day yr.
Type of Leave	From	Thru	Type of Leave	From
				Thru
30. If employee received continuation of pay (COP), give dates.				
31. Date all pay stopped				
mo. day yr.	Hour	<input type="checkbox"/> AM <input type="checkbox"/> PM	32. Period for which compensation is claimed	
			From mo. day yr. Thru mo. day yr.	
Return to Duty				
33. Date returned to work				
mo. day yr.	Hour	<input type="checkbox"/> AM <input type="checkbox"/> PM	34. Work schedule when returned to work	
			<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat	
35. Did the work assignment change because of disability resulting from the injury? Describe.				
<input type="checkbox"/> Yes <input type="checkbox"/> No				
36. Pay rate on return to work				
\$ Per				
Certification				
37. A supervisor who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respects to this claim may also be subject to appropriate felony criminal prosecution				
I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:				
Signature of supervisor _____ Date _____				
Supervisor's title _____				
Agency name & address _____ Office phone _____				
38. If OWCP needs specific pay information the person who should be contacted is				
<input type="checkbox"/> Supervisor <input type="checkbox"/> Other: Name _____ Phone _____				

Form CA-7

Attending Physician's Report

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



Record of Examination 1. Patient's name Last First Middle			2. Date of injury mo. day yr.		3. OWCP File Number OMB No. 1215-0103 Expires: 10-31-99	
4. What history of injury (including disease) did patient give you?						
5. Is there any history of evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe) <input type="checkbox"/> Yes <input type="checkbox"/> No						ICD-9 Code _____
6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)						
7. What is your diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No						ICD-9 Code _____
8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer) <input type="checkbox"/> Yes <input type="checkbox"/> No						
9. Did injury require hospitalization? If no, go to item #13 <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Date of admission mo. day yr.		11. Date of discharge mo. day yr.		12. Additional hospitalization required If Yes, describe in "Remarks" (Item 25) <input type="checkbox"/> Yes <input type="checkbox"/> No
13. What treatment did you provide?						
4. Date of first examination mo. day yr.		15. Date(s) of treatment mo. day yr.		16. Date of discharge from treatment mo. day yr.		
17. Period of total disability From mo. day yr. Thru mo. day yr.		18. Period of Partial Disability From mo. day yr. Thru mo. day yr.		19. Date employee able to resume light work mo. day yr.		
20. Date employee is able to resume regular work mo. day yr.		21. Has employee been advised that he/she can return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		22. If yes, on what date was he/she advised? mo. day yr.		
23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #25 if necessary.)				24. Are any permanent effects expected as a result of this injury? If yes, describe in item #25. <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Remarks						
26. If you have referred the employee to another physician provide the following: Name _____ Address _____ City _____ State _____ ZIP _____					Specialty _____ 27. What was the reason for this referral? <input type="checkbox"/> Consultation <input type="checkbox"/> Treatment	
Signature 28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.						
Signature of Physician _____ Date _____					30. Tax ID Number A-11	
29. Name of Physician _____ Address _____ City _____ State _____ ZIP _____					31. Do you specialize? <input type="checkbox"/> Yes <input type="checkbox"/> No 32. If yes, indicate specialty _____	

INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not qualify for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be included after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

EMPLOYEE (or person acting on the employee's behalf) - Complete items 1 through 20 and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) - Complete items 21 through 38 and promptly forward the form to OWCP.

ITEM EXPLANATIONS - Some of the items on the form which may require further clarification are explained below:

Item Number	Explanation
4) Period of Wage Loss for which Compensation is Claimed	Enter inclusive dates covering the period for which you are claiming compensation. If intermittent periods are claimed, use a separate sheet to list each period individually.
5) Is This a Claim for a Schedule Award?	Schedule awards are paid for permanent impairment to a member or function of the body. A claim for a schedule award should not be made on the same form as a claim for compensation for wage loss; rather, a separate CA-7 should be used.
6) Has Any Pay Been Received for Period Shown in Item 4?	This question includes leave pay and COP received from the Federal job in which you were injured; and pay for work actually performed, whether at the Federal job in which you were injured or at other employment (including self-employment).
7) If Yes, Amount	Give the amount of pay received and the period for which it was paid. If there is more than one period, or more than one source of pay, explain fully on a separate sheet.
9) Was Claim Made Against 3rd Party?	A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
14) List Your Dependents	Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he or she either lives with you or receives support payments from you, and he or she: 1) is under 18; or 2) is between 18 and 23 and is a full-time student; or 3) is incapable of self-support due to physical or mental disability.
22) If Employee Received Additional Pay, Identify Type and Show Amount	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
29) Type and Inclusive Dates Employee Received Leave for Any Part of Period Since Stopping Work	Enter inclusive dates covering each period of leave. If leave was used for more than four individual periods, continue on a separate sheet. If leave was used for part of each day during a period, state how many hours were used per day; if the number of hours used per day varied, use a separate sheet to list each day.
30) Dates of Pay Continuation (COP) During Period of Disability	Enter the period of Continuation of Pay (see form CA-1 for a full explanation). If the injury was not a traumatic injury reported on form CA-1, this item does not apply.
31) Date All Pay Stopped	No compensation is payable for temporary total disability until the employee enters a non-pay status; therefore, item 30 refers to termination of all pay, including leave. Compensation is not payable for the first three days of disability after the end of any COP unless the disability exceeds 14 calendar days.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, NW, Wash., D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION FOR LOSS OF WAGES OR PERMANENT DISABILITY CAN BE MADE TO THE EMPLOYEE. THIS INFORMATION IS REQUIRED TO OBTAIN OR RETAIN A BENEFIT (5 USC §101 et seq.).

IF YOU HAVE SUBMITTED A NARRATIVE MEDICAL REPORT OR A FORM CA-16 TO OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA 1500/OWCP-1500a.

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 1-32 ON THE FORM; AND
2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 17; AND
3. SEND THE FORM AND YOUR BILL TO:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3228, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

For Sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

A-13

FORM CA-20, PHYSICIAN'S REPORT

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the employee should detach Form CA-20, complete items 1-3 on the front, and print the OWCP district office address on the reverse. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease, filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The employee should bring these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award, the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.304). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Medical Association Guides to the Evaluation of Permanent Impairment.

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.), is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefit. (Disclosure of a social security number (SSN) is required by P.L. 103-298 108 Stat. 1464. Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefit and payment files.)

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.

U.S. Government Printing Office: 1997 - 575-783

A-14

U.S. Department of Labor

Employment Standards Administration
 Office of Workers' Compensation Programs
 1111 Third Avenue, Suite 650
 Seattle, WA 98101-3211
 Telephone # (206) 553-5508



April 1991

File Number:

Dear Doctor:

The Office of Workers' Compensation Programs (OWCP) maintains a roster of physicians who are willing to do second opinion and medical referee examinations of Federal employees with traumatic injuries or occupational diseases. These medical evaluations are needed as a complement to existing evidence or to act as a referee examination in cases where there is a conflict of medical opinion.

Both types of evaluations involve the physical examination of the worker, the review of the medical records (for second opinion examination), a review of our entire case file (for referee examinations), and the submission of a written medical report answering specific questions posed by the OWCP claims examiner. In the report you will be asked to give your opinion on issues such as the etiology of the condition and its medical relationship to the workplace, recommendations for treatment, prognosis, and the assessment of any resulting physical impairment.

We pay full fees and promptly if you use the special billing form which we supply. We rotate among those willing to do our examinations and now have an automated computer program to give all interested persons equal opportunity to give this much needed advice to our claim development.

We would like to hear from you. If you would be interested in being on our roster, please complete the simple attached form and mail it to me using the envelope provided. If you have done this type of work for us previously, please excuse this duplication, however we would like to update our records. If we do not receive a response we will assume that you chose not to perform second opinion or referee examinations for OWCP.

If you or your staff have any questions, please call me at 206-553-0120.

Sincerely,

Robert Reynolds, M.D.
 District Medical Director

Enclosure

(B-1)

MEMO TO: PHYSICIANS AND STAFF OF A.F.O.C.

FROM: BETH *BA* (AFOC Administrator Beth Schwab)

DATE: June 28, 1991

RE: 90 DAY TRIAL OF SEEING FEDERAL WORKER'S COMPENSATION PATIENTS

I have notified Dr. Reynolds of USDL workers comp division that we have agreed to a 90 day trial of seeing limited types of Federal Workers Comp patients.

He has been informed that the type of cases which we will see are new trauma, and acute cases. We will NOT be seeing chronic backs, second opinions, or IMEs. Information is being sent to Federal agencies in Alaska, but it will be up to us to screen the types of patients that we will and will not see.

I have also been told by Dr. Reynolds that we will NOT need to fill out ANY of the special federal forms. He said that if we send our chart notes and work releases along with our standard billing forms that this will suffice.

We will need to preauthorize all non-emergency surgery with Dr. Reynolds in Seattle. His direct phone number is (206)553-0120 His fax number is (206)553-4629.

Dr. Reynolds has agreed to be our contact person to resolve any problems which may occur. This includes billing and timely reimbursement issues. If anyone has problems with the USDL systems during the next 90 days PLEASE let me know.

(B-2)

WIRED PATIENTS STING ALASKA DOCS

By Gail Sage-Bundy
Executive Editor, Orthopedic INSIGHT

The chart said the new patient, a postal worker at Alaska's central mail sorting center, had strained her shoulder lifting mailbags. The orthopedist grimaced. Federal worker's comp cases were hardly worth taking anymore — the paperwork was horrendous and it took months to get paid. But, he reminded himself, he had gone into medicine to take care of patients, and there was one waiting for him in the exam room. He had no way of knowing that the "patient" was an investigator hired by the U.S. Dept. of Labor to manipulate him into making a mistake. He had no way of knowing that she was wearing a wire, or that slow payment and paperwork would soon be the least of his worries over the case. He was about to be stung.

The Anchorage orthopedist was one of 16 Alaskan physicians fingered in an undercover sting operation by the U.S. Dept. of Labor. Two agents, a man and a woman, were sent into doctors' offices posing as postal workers with job-related injuries. Once inside the exam room, they changed their stories. The trick was to see whether the doctor could be talked into authorizing time off work even after the patient admitted to faking the injury. Most couldn't. But that wasn't enough to redeem them in the eyes of the government. They had been targeted for a sting — therefore, they had to be guilty of something. It simply wouldn't do have an undercover investigation whose end result was a finding that the targeted doctors were honest.

The bogus office visits, all preserved on tape, occurred between the fall of 1987 and spring of 1988. "The state medical association knew nothing about it until July 15,

They had been targeted for a sting — therefore, they had to be guilty of something. It simply wouldn't do to have an undercover investigation whose end result was a finding that the targeted doctors were honest.

1988, when it hit the front page of the newspapers," explains Ray Schalow, ASMA's executive director. "The thrust of the story, of course, was that physicians and postal workers were scamming the government out of thousands of dollars. Reputations were destroyed that day."

Schalow demanded a meeting with the federal prosecutor assigned to the case. He took along the medical association's attorney, the executive director of the Medical Disciplinary Board and the investigator for the State Department of Occupational Licensing. "The government came on like gangbusters at that meeting," Schalow recalls. "They said they had targeted the small group of physicians with the heaviest caseload of postal worker patients. Out of an initial group of 20, 16 went on to examine the patient after being told that they weren't really injured. Seven cases went before the grand jury, and five doctors were indicted. The government's attorney told us that they could have gotten indictments on all seven but decided that five was enough." As for the other nine physicians who had examined the

patients, the attorney wouldn't concede that their conduct had been proper — only that there had been insufficient evidence to take their cases before a grand jury.

"Sometime later, our attorney got his hands on a tape of one of the office visits," Schalow continued. "It was pretty bad. The prosecutor led us to believe that all the tapes were equally damning."

"What had in fact happened was that the government allowed only the worst tape to be leaked. The other cases were entirely different. Only one of the 16 — the one whose tape we had heard — was convicted of fraud. One other physician plead guilty to a misdemeanor. In 14 out of the 16 cases, the government either didn't have enough on the doctor to take it to the jury, or the jury wouldn't buy their arguments."

The doctors insist that the reason their cases went nowhere was because they had done nothing wrong in the first place.

"When I got into the exam room, the patient told me that there was nothing wrong with her shoulder, but that she wanted time off to visit her boyfriend in Hawaii," says the orthopedist. "I told her right off the bat that I wouldn't authorize time off. The next thing she did was burst into tears and tell me that she'd lose her job if the postal service found out what she had done."

"Out of compassion, I said I would go ahead and fill out a duty status report, confirming that she had come to me

"I guess if somebody comes into my office under phony pretenses, puts my staff to the expense of setting up a chart, takes up my time while other patients wait, then admits that the whole thing is a scam, I'm not supposed to bill for it. If I keep no records, that's acceptable. If I bill for my time and document it, that's misrepresentation."

complaining of shoulder pain. That was the truth. I billed for an office visit. The Department can't deny that I examined the patient — they've got that on tape."

But early this year, he and the 10 other physicians who were not indicted got letters from the regional director of the Dept. of Labor, informing them that they were being "excluded from payment and participation as a provider of

medical services to injured federal workers under the Federal Workers Compensation Act."

"What they contend is that I knowingly gave false statements in connection with a request for payment," says the orthopedist. "I guess if someone comes into my office under phony pretenses, puts my staff to the expense of setting up a chart, takes up my time while other patients wait, then admits that the whole thing is a scam, I'm not supposed to bill for it. If I bill for my time and document it, that's misrepresentation."

"The trial cost me \$50,000 in direct costs, and at least \$200,000 in indirect costs. The emotional cost... is truly immeasurable. Most importantly, the time and energy which I had to devote to these misguided proceedings was taken away from the people who needed my services the most — my patients."

"The government went looking under rocks for problems, on the assumption that the doctors had to be doing something wrong. They dragged us through hell on the flimsiest of charges. When they couldn't find anything solid to pin on us, they accused us of misrepresenting facts. 'What really galls me is that these people have no personal liability for what they do. They can wreck lives and careers and just walk away.'"

The Department came down especially hard on one of the five physicians it took to trial. It took the jury only 20 minutes to exonerate him. Later, he got a letter from the government telling him that even though a jury had judged him innocent, he was being excluded from the workers' comp program.

"This man is an absolute prince, and what's been done to him is unconscionable," rages Schalow. "He specializes in sports medicine and is on the U.S. Olympic Committee. Every year, he gives over 500 exams to high school athletes and turns every cent he collects from that over to the schools to fund their sports programs. He's a tremendous asset to the community and the state, and an outstanding person. He's not out to bilk anybody."

And he's been devastated by the sting. "The trial cost me \$50,000 in direct costs, and at least \$200,000 in indirect costs," he writes. "The emotional cost to me, my family and my office staff was truly immeasurable. Most importantly, the time and energy which I had to devote to these misguided proceedings was taken away from the people who needed my services the most — my patients."

"During my trial, the federal undercover agent admitted she had lied to the grand jury, and that her perjured testimony was the basis for my indictment. Nevertheless, the Dept. of Labor now states in an administrative action that they find me guilty of those same charges. They propose to prevent me from caring for any federal employees under the workers' comp program."

"The horror in all this," says Schalow, "is that if the government can't trick the doctors into doing something wrong, they'll find a way to punish them anyway."

"These guys weren't out to defraud the government. Physicians are trained from the very beginning to be advocates for their patients. That's all they were doing. If that constitutes fraud, then I guess fraud is the basis of our health care system."

"During my trial, the federal undercover agent admitted she had lied to the grand jury, and that her perjured testimony was the basis for my indictment. Nevertheless, the Dept. of Labor now states in an administrative action that they find me guilty of those same charges."

"These 16 doctors, most of them orthopedists, have been put through hell. But they're not the only ones who have been stung. This is an insult to the whole profession, and to society. It's not how I want my tax dollars spent."

It may also turn out to be an expensive sting for the government. Physicians say it will cost the Department thousands of extra dollars each year to secure treatment for injured workers, many of whom will now need to be flown to Seattle.

"The sting was aimed directly at the few general orthopedists and family physicians who would agree to take postal workers. Now most of us are excluded from the program. And those who aren't excluded aren't particularly impressed with the way the Dept. of Labor does business. This sting... isn't going to make anyone more anxious to take care of patients for the government."

"We're losing physicians in Alaska already," explains the orthopedist. "And many of our 42 orthopedic surgeons are subspecialists, who generally don't see these patients anyway. The sting was aimed directly at the few general orthopedists and family physicians who would agree to treat the postal workers. Now most of us are excluded from the program."

"And those who aren't excluded aren't particularly impressed with the way the Dept. of Labor does business. This sting certainly isn't going to make anyone more anxious to take care of patients for the government."



(B-4)

-----S T A T E M E N T O F A C C O U N T-----

For the period 02/27/97 Thru 04/27/99
 ANCH FRACTURE & ORTHO CLINIC
 3260 PROVIDENCE DR., SUITE 200
 ANCHORAGE, AK 99508
 907-563-3145

Statement date: 05/06/99 KH PAGE 2
 TO: [REDACTED]
 ANCHORAGE, AK 99504

Account# CC113599 Ins prov# Prov# IRS# 92-0039318
 Tel: 907-[REDACTED] Cht# 00CC113599 Birth: 03/12/50 SS# [REDACTED]

DATE	PROV	PL	NAME	SERV	SERVICE DESCRIPTION	ICDA	AMOUNT
Claim # 7							
02/27/97	35		DEAN	COWC	OUT OF STATE FEE SCHEDUL		737.00-
01/07/98	35	OH	DEAN	64721	CARPAL TUNNEL RELEASE	3540	1428.00
02/27/98	35		DEAN	PWC	PAYMENT BY WORKERS' COMP		691.00-
					USDL		
*****TOTAL OF CLAIM TRANS *****							\$.00

Claim # 8							
02/05/98	35	DO	DEAN	99024	POSTOPERATIVE FOLLOW UP	3540	.00
*****TOTAL OF CLAIM TRANS *****							\$.00

Claim # 9							
02/05/98	35	DO	DEAN	L3908	COCK-UP WRIST SPLINT	3540	20.50
03/03/98	35		DEAN	PWC	PAYMENT BY WORKERS' COMP		20.50-
					USDL		
*****TOTAL OF CLAIM TRANS *****							\$.00

Claim # 10							
02/19/98	35	DO	DEAN	99024	POSTOPERATIVE FOLLOW UP	3540	.00
*****TOTAL OF CLAIM TRANS *****							\$.00

Claim # 11							
01/30/98	35	OH	DEAN	64721	CARPAL TUNNEL RELEASE	3540	1428.00
04/02/98	35		DEAN	PWC	PAYMENT BY WORKERS' COMP		691.00-
					USDL		
04/24/98	35		DEAN	COWC	OUT OF STATE FEE SCHEDUL		737.00-
*****TOTAL OF CLAIM TRANS *****							\$.00

Claim # 12							
02/20/98	35	DO	DEAN	99080	SPECIAL REPORTS OR FORMS		25.00
03/30/98	35		DEAN	PWC	PAYMENT BY WORKERS' COMP		25.00-
					USDL		
*****TOTAL OF CLAIM TRANS *****							\$.00

Claim # 13							
03/24/98	35	DO	DEAN	99080	LETTER		25.00
04/23/98	35		DEAN	PWC	PAYMENT BY WORKERS' COMP		25.00-
					USDL		

(C-1)

NOTICE TO CHECK RECIPIENT		TREASURY-FINANCIAL MANAGEMENT SERVICE TFS FORM 5096 (Rev. 1)		
ENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLN01		VENDOR I.D. NUMBER: L920039318AB		
ENCL NAME	US DEPT OF LABOR, ESA/OWCP	U.S. TREASURY REG. FINANCIAL CENTER:	PHILADELPHIA, PA	
B BILLING	1111 3RD AVE	CHECK NUMBER	CHECK AMOUNT	CHECK DATE
ADDRESS:	SUITE 650	2038-53617748	*****691.00	02-20-98
	SEATTLE, WA. 98101-3211			
THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.				AGENCY SCHEDULE NUMBER
				0114980219
				AGENCY TELEPHONE NUMBER
				206-553-5508
140278066 D 01/07-01/07/98 1,428.00 737.00 691.00 CC113599				

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS (OR PHONE NUMBER) INDICATED ABOVE

(C-2)

NOTICE TO CHECK RECIPIENT		TREASURY-FINANCIAL MANAGEMENT SERVICE TFS FORM 3490 (Rev. 1)	
VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLN01		VENDOR I.D. NUMBER: L920039318AA	
AGENCY NAME AND BILLING ADDRESS:	US DEPT OF LABOR, ESA/OWCP 1111 5RD AVE SUITE 650 SEATTLE, WA. 98101-3211	U.S. TREASURY REG. FINANCIAL CENTER:	PHILADELPHIA, PA
	CHECK NUMBER: 2038-33006180	CHECK AMOUNT: \$****691.00	CHECK DATE: 03-26-98
THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.			AGENCY SCHEDULE NUMBER: 0114980326
140278066 D [REDACTED] CC113599 01/30-01/30/98 1,428.00 737.00 691.00			AGENCY TELEPHONE NUMBER: 206-553-5508

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS (OR PHONE NUMBER) INDICATED ABOVE

C-3

-----S T A T E M E N T O F A C C O U N T-----
 For the period 09/30/93 Thru 04/27/99
 ANCH FRACTURE & ORTHO CLINIC
 3260 PROVIDENCE DR., SUITE 200
 ANCHORAGE, AK 99508
 907-563-3145

Statement date: 05/06/99 KH PAGE 2
 TO: [REDACTED]
 ANCHORAGE, AK 99521

Account# CB115860 Ins prov# Prov# IRS# 92-0039318
 Tel: 907- [REDACTED] Cht# CB115860 Birth: 01/19/43 SS# [REDACTED]

DATE	PROV	PL NAME	SERV	SERVICE DESCRIPTION	ICDA	AMOUNT
01/09/98 65		RAYMOND	PWC	PAYMENT BY WORKERS' COMP		98.00-
			USDL			
01/23/98 65		RAYMOND	COWC	OUT OF STATE FEE SCHEDUL		15.00-
*****TOTAL OF CLAIM TRANS *****						\$.00

Claim # 7						
08/12/97 65	DO	RAYMOND	99210	ESTABLISHED PATIENT VISI	72210	52.00
01/09/98 65		RAYMOND	PWC	PAYMENT BY WORKERS' COMP		46.00-
			USDL			
01/23/98 65		RAYMOND	COWC	OUT OF STATE FEE SCHEDUL		6.00-
*****TOTAL OF CLAIM TRANS *****						\$.00

Claim # 8						
09/18/97 35	DO	RAYMOND	99022	PRE-OP VISIT; ONE DAY PRI	72210	.00
*****TOTAL OF CLAIM TRANS *****						\$.00

Claim # 9						
09/23/97 35	DO	RAYMOND	99024	POSTOPERATIVE FOLLOW UP	72210	.00
*****TOTAL OF CLAIM TRANS *****						\$.00

Claim # 10						
09/19/97 35	OH	RAYMOND	630302	CLAMINOTOMY	72210	5227.50
09/23/97 35	DO	RAYMOND	72100	LUMBAR XRAYS (3V)	72210	108.00
01/09/98 35		RAYMOND	PWC	PAYMENT BY WORKERS' COMP		2162.00-
			USDL			
01/23/98 35		RAYMOND	COWC	OUT OF STATE FEE SCHEDUL		3173.50-
*****TOTAL OF CLAIM TRANS *****						\$.00

Claim # 11						
10/07/97 35	DO	RAYMOND	99024	POSTOPERATIVE FOLLOW UP	72210	.00
*****TOTAL OF CLAIM TRANS *****						\$.00

Claim # 12						
11/04/97 35	DO	RAYMOND	99024	POSTOPERATIVE FOLLOW UP	72210	.00
*****TOTAL OF CLAIM TRANS *****						\$.00

(C-4)

NOTICE TO CHECK RECIPIENT		TREASURY-FINANCIAL MANAGEMENT SERVICE TFS FORM 3996 (Rev. 1-93)		
VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLN01		VENDOR I.D. NUMBER: L920039318AA (1/9/98)		
AGENCY NAME AND BILLING ADDRESS: US DEPT OF LABOR, ESA/OWCP 1111 3RD AVE SUITE 650 SEATTLE, WA. 98101-3211		U.S. TREASURY REG. FINANCIAL CENTER: PHILADELPHIA, PA		
		CHECK NUMBER: 2038-31863948	CHECK AMOUNT: \$***2343.50	CHECK DATE: 01-02-98
THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.		AGENCY SCHEDULE NUMBER: 0114980101		
140288912 R [REDACTED]		AGENCY TELEPHONE NUMBER: 206-553-5508		
CB115860	08/08-08/08/97	113.00	15.00	-98.00 (6)
CB115860	08/12-08/12/97	32.00	6.00	-26.00 (7)
CB115860	08/19-08/19/97	5,227.50	3,125.00	-2,102.50 (10) - 2162.50
CB115860	09/23-09/23/97	106.00	48.00	-58.00 (11)
CB115860	11/04-11/04/97	37.50	.00	-37.50 (13)

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS (OR PHONE NUMBER) INDICATED ABOVE

(C-5)

-----S T A T E M E N T O F A C C O U N T-----
 For the period 05/28/98 Thru 04/27/99
 ANCH FRACTURE & ORTHO CLINIC
 3260 PROVIDENCE DR., SUITE 200
 ANCHORAGE, AK 99508
 907-563-3145

Statement date: 05/06/99 KH PAGE 1
 TO: [REDACTED]
 GAKONA, AK 99586

Account# CA140644 Ins prov# Prov# IRS# 92-0039318
 Tel: 907- [REDACTED] Cht# CA140644 Birth: 04/10/60 SS#: [REDACTED]

DATE	PROV PL NAME	SERV	SERVICE DESCRIPTION	ICDA	AMOUNT
Claim # 1					
05/28/98 65	DO MARK	99204	NEW PATIENT OFFICE VISIT	72210	197.00
07/08/98 65	MARK	PWC	PAYMENT BY WORKERS' COMP		172.00-
			USDL		
07/24/98 65	MARK	COWC	OUT OF STATE FEE SCHEDUL		25.00-
			*****TOTAL OF CLAIM TRANS *****		\$.00
Claim # 2					
06/12/98 65	DO MARK	99023	PRE-OP VISIT; ONE DAY PRI	72210	.00
			*****TOTAL OF CLAIM TRANS *****		\$.00
Claim # 3					
06/12/98 65	OH MARK	63030	LAMINOTOMY	72210	4182.00
07/29/98 65	MARK	PWC	PAYMENT BY WORKERS' COMP		2075.00-
			USDL		
07/31/98 65	MARK	COWC	OUT OF STATE FEE SCHEDUL		2107.00-
			*****TOTAL OF CLAIM TRANS *****		\$.00
Claim # 4					
06/12/98 35	OH MARK	63030	ASST DR PETERSON	72210	1045.50
07/29/98 35	MARK	PWC	PAYMENT BY WORKERS' COMP		415.00-
			USDL		
07/31/98 35	MARK	COWC	OUT OF STATE FEE SCHEDUL		630.50-
			*****TOTAL OF CLAIM TRANS *****		\$.00
Claim # 5					
07/02/98 65	DO MARK	99024	POSTOPERATIVE FOLLOW UP	72210	.00
			*****TOTAL OF CLAIM TRANS *****		\$.00
Claim # 6					
08/11/98 65	DO MARK	99024	POSTOPERATIVE FOLLOW UP	72210	.00
			*****TOTAL OF CLAIM TRANS *****		\$.00
Claim # 7					
10/08/98 65	DO MARK	99212	ESTABLISHED PATIENT VISI	72210	52.00

(C-6)



Pay to
the order of

L920039318AD M2 OWCP-MISC. 0114980702 16152001

ANCHORAGE FRAC AND ORTHOPEDIC CLN01
3260 PROVIDENCE DRIVE NUM 200
ANCHORAGE AK 99508

\$****172*00

VOID AFTER ONE YEAR

PER ENCLOSED MAILING NOTICE



#20383#

000000518: 338109310# 010798

NOTICE TO CHECK RECIPIENT		TREASURY-FINANCIAL MANAGEMENT SERVICE (TFS FORM 109810-01)	
VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLN01		VENDOR I.D. NUMBER: L920039318AD	
AGENCY NAME: AND ADDRESS: ADDRESS2:	US DEPT OF LABOR,ESA/OWCP 1111 3RD AVE SUITE 650 SEATTLE, WA. 98101-3211	U.S. TREASURY REF. FINANCIAL CENTER:	PHILADELPHIA, PA
	CHECK NUMBER	CHECK AMOUNT	CHECK DATE
	2038-33810931	\$****172.00	07-02-98
THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.			AGENCY SCHEDULE NUMBER
140333858 M SABBATINI CA14064400 05/28-05/28/98			0114980702
197.00 25.00 172.00			AGENCY TELEPHONE NUMBER
			206-553-5508

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS (OR PHONE NUMBER) INDICATED ABOVE

C-7

NOTICE TO CHECK RECIPIENT		TREASURY-FINANCIAL MANAGEMENT SERVICE TFS FORM 5090(Rew.)	
NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLN01		VENDOR I.D. NUMBER: L920039318AE	
AGENCY NAME AND BILLING ADDRESS:	US DEPT OF LABOR, ESA/OWCP 1111 3RD AVE SUITE 650 SEATTLE, WA. 98101-3211	U.S. TREASURY REG. FINANCIAL CENTER:	PHILADELPHIA, PA
	CHECK NUMBER: 2038-34257451	CHECK AMOUNT: \$***2490.00	CHECK DATE: 07-23-98
THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.			AGENCY SCHEDULE NUMBER: 0114980723
140333858 M CA140644 08/12-08/12/98 4,182.00 2,107.00 -2,075.00 1,045.00 2,630.00 -2,415.00			AGENCY TELEPHONE NUMBER: 206-553-5508

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS (OR PHONE NUMBER) INDICATED ABOVE.

(C-8)

-----S T A T E M E N T O F A C C O U N T-----
 For the period 01/09/97 Thru 05/04/99
 ANCH FRACTURE & ORTHO CLINIC
 3260 PROVIDENCE DR., SUITE 200
 ANCHORAGE, AK 99508
 907-563-3145

TO: [REDACTED] Statement date: 05/06/99 KH PAGE 5
 WASILLA, AK 99654-2243

Account# CA87021 Ins prov# Prov# IRS# 92-0039318
 Tel: 907- [REDACTED] Cht# 000CA87021 Birth: 07/05/53 SS#: [REDACTED]

DATE	PROV	PL	NAME	SERV	SERVICE DESCRIPTION	ICDA	AMOUNT
07/31/98	65		PAUL	COWC	OUT OF STATE FEE SCHEDUL		5.00-
*****TOTAL OF CLAIM TRANS *****							\$.00

Claim #	22						
07/24/98	65	DO	PAUL	99023	PRE-OP VISIT; ONE DAY PRI	7220	.00
*****TOTAL OF CLAIM TRANS *****							\$.00

Claim #	23						
07/31/98	65	DO	PAUL	99024	POSTOPERATIVE FOLLOW UP	7220	.00
*****TOTAL OF CLAIM TRANS *****							\$.00

Claim #	24						
07/27/98	65	IN	PAUL	22554	NECK SPINE FUSION	7222	4345.00
07/27/98	65	IN	PAUL	630755	DISCECTOMY	7222	2171.50
07/27/98	65	IN	PAUL	20938	AUTOGRAFT FOR SPINE SURG	7222	580.00
09/11/98	65		PAUL	PWC	PAYMENT BY WORKERS' COMP		5136.00-
					USDL		
09/28/98	65		PAUL	COWC	OUT OF STATE FEE SCHEDUL		1960.50-
*****TOTAL OF CLAIM TRANS *****							\$.00

Claim #	25						
08/27/98	65	DQ	PAUL	99024	POSTOPERATIVE FOLLOW UP	7220	.00
*****TOTAL OF CLAIM TRANS *****							\$.00

Claim #	26						
08/27/98	65	DO	PAUL	72020	SPINE XRAY (1V ANY LEVEL	7220	70.00
09/24/98	65		PAUL	PWC	PAYMENT BY WORKERS' COMP		41.00-
					USDL		
11/02/98	65		PAUL	COWC	OUT OF STATE FEE SCHEDUL		29.00-
*****TOTAL OF CLAIM TRANS *****							\$.00

Claim #	27						
1 3/98	65	DO	PAUL	992132	ESTABLISHED PATIENT VISI	7220	73.00
1 3/98	65	DO	PAUL	20605	ARTHROCENTESIS	7220	126.00
11/13/98	65	DO	PAUL	72020	SPINE XRAY (1V ANY LEVEL	7220	70.00

(C-9)

NOTICE TO CHECK RECIPIENT		TREASURY-FINANCIAL MANAGEMENT SERVICE TFS FORM 3090 (Rev.)		
VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLN01		VENDOR I.D. NUMBER: L920039318AB		
AGENCY NAME	U.S. DEPT OF LABOR, ESA/OWCP	U.S. TREASURY REG. FINANCIAL CENTER:	PHILADELPHIA, PA	
IND BILLING ADDRESS:	1111 3RD AVE SUITE 650 SEATTLE, WA. 98101-3211	CHECK NUMBER	CHECK AMOUNT	CHECK DATE
		2038-34544674	****5136.00	09-04-98
THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.				
140320388 P [REDACTED]				
CAB70210	07/27-07/27/98	4,345.00	1,260.00	3,085.00
CAB70210	07/27-07/27/98	2,171.80	700.50	1,471.30
CAB70210	07/27-07/27/98	580.00	1.00	580.00
<div style="border: 1px solid black; padding: 2px; display: inline-block;"> AGENCY SCHEDULE NUMBER 0114980903 </div>				
<div style="border: 1px solid black; padding: 2px; display: inline-block;"> AGENCY TELEPHONE NUMBER 206-553-5508 </div>				

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS (OR PHONE NUMBER) INDICATED ABOVE

C-10

-----S T A T E M E N T O F A C C O U N T-----

For the period 08/07/96 Thru 05/04/99
 ANCH FRACTURE & ORTHO CLINIC
 3260 PROVIDENCE DR., SUITE 200
 ANCHORAGE, AK 99508
 907-563-3145

Statement date: 05/06/99

KH PAGE 1

TO: [REDACTED]
 [REDACTED]
 ANCHORAGE, AK 99508

Account# CB123230 Ins prov# Prov# IRS# 92-0039318
 Tel: 907- [REDACTED] Cht# 00CB123230 Birth: 12/13/25 SS#: [REDACTED]

DATE	PROV	PL NAME	SERV	SERVICE DESCRIPTION	ICDA	AMOUNT
------	------	---------	------	---------------------	------	--------

Claim # 3						
09/17/96 45	DO	FREDERICK	9921357	ESTABLISHED PATIENT VISI	72402	72.00
10/30/96 45	FREDERICK	PWC		PAYMENT BY WORKERS' COMP		58.00-
				USDL		
11/15/96 45	FREDERICK	COWC		OUT OF STATE FEE SCHEDUL		14.00-
				*****TOTAL OF CLAIM TRANS *****		\$.00

Claim # 4						
10/15/96 45	DO	FREDERICK	99023	PRE-OP VISIT;ONE DAY PRI	72402	.00
				*****TOTAL OF CLAIM TRANS *****		\$.00

Claim # 5						
10/21/96 45	IH	FREDERICK	63047	L3	72402	5075.00
10/21/96 45	IH	FREDERICK	63048	L4	72402	1600.00
10/21/96 45	IH	FREDERICK	2261251	L4-S	72402	2316.50
10/21/96 45	IH	FREDERICK	22614	L5-S1	72402	1366.00
10/21/96 45	IH	FREDERICK	2097551	ELECTRICAL BONE STIMUL (72402	575.00
12/30/96 45	FREDERICK	PWC		PAYMENT BY WORKERS' COMP		3980.00-
				USDL		
12/30/96 45	FREDERICK	PWC		PAYMENT BY WORKERS' COMP		1752.00-
				USDL		
01/10/97 45	FREDERICK	COWC		OUT OF STATE FEE SCHEDUL		5200.50-
				*****TOTAL OF CLAIM TRANS *****		\$.00

Claim # 6						
10/21/96 65	IH	FREDERICK	6304780	ASST DR VASILEFF	72402	1268.75
10/21/96 65	IH	FREDERICK	6304880	REMOVAL OF SPINAL LAMINA	72402	400.00
10/21/96 65	IH	FREDERICK	2261280	LUMBAR SPINE FUSION	72402	579.12
11/1/96 65	IH	FREDERICK	2261480	LUMBAR ARTHRO /ADDL SEGM	72402	341.50
11/21/96 65	IH	FREDERICK	2097580	ELECTRICAL BONE STIMUL (72402	143.75
12/30/96 65	FREDERICK	PWC		PAYMENT BY WORKERS' COMP		1463.12-
				USDL		
01/10/97 65	FREDERICK	COWC		OUT OF STATE FEE SCHEDUL		1270.00-
				*****TOTAL OF CLAIM TRANS *****		\$.00

(C-11)

[illegible]

C-12

United States Treasury 15-51
000 M 089,652,488

Check No. 2036 9839199

12 16 96 13 PHILADELPHIA, PA L920039318AD M2 OMCP=MISC. 0114961212 161520

Pay to the order of ANCHORAGE FRAC AND ORTHOPEDIC CLN01
3260 PROVIDENCE DRIVE NUM 200
ANCHORAGE AK 99508

\$\$\$1752.00

VOID AFTER ONE YEAR

PER ENCLOSED MAILING NOTICE

20361# 10000005181 983919915# 011296

NOTICE TO CHECK RECIPIENT TREASURY FINANCIAL MANAGEMENT SERVICE TFS FORM 800 (Rev. 3)

VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLN01	VENDOR I.D. NUMBER: L920039318AD
US DEPT OF LABOR, ESA/OMCP 1111 3RD AVE SUITE 650 SEATTLE, WA 98101-3211	US TREASURY BUD. FINANCIAL OFFICE: PHILADELPHIA, PA
CHECK NUMBER: 2036-98391991	CHECK AMOUNT: \$\$\$1752.00
CHECK DATE: 12-16-96	AGENCY SCHEDULE NUMBER: 0114961212
AGENCY TELEPHONE NUMBER: 206-553-5506	

THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.

140316774	F	140316774	1,400.00	991.00	1,400.00
140316774	F	140316774	1,400.00	991.00	1,400.00
140316774	F	140316774	1,400.00	991.00	1,400.00
140316774	F	140316774	1,400.00	991.00	1,400.00

NON NEGOTIABLE

0812330 - CUS = 1752.00

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS OR TELEPHONE NUMBER INDICATED ABOVE

(C-13)

United States Treasury 15-51 P 629,430,470

Check No. 2038 31009396

09 22 97 85 PHILADELPHIA, PA
L920039318AA M2 OWCP-MISC. 0114970918 16152001

Pay to the order of ANCHORAGE FRAC AND ORTHOPEDIC CLN01
3260 PROVIDENCE DRIVE NUM 200
ANCHORAGE AK 99508

*****500*00
VOID AFTER ONE YEAR

PER ENCLOSED MAILING NOTICE

⑈ 20383 ⑈ ⑆000000518⑆ 310093960 ⑈ 010997

NOTICE TO CHECK RECIPIENT TREASURY-FINANCIAL MANAGEMENT SERVICE TFS FORM 5090 (Rev. 1)

VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLN01		VENDOR I.D. NUMBER: L920039318AA	
AGENCY NAME AND BILLING ADDRESS:	US DEPT OF LABOR, ESA/OWCP 1111 3RD AVE SUITE 650 SEATTLE, WA. 98101-3211	U.S. TREASURY REG. FINANCIAL CENTER:	PHILADELPHIA, PA
	CHECK NUMBER	CHECK AMOUNT	CHECK DATE
	2038 31009396	*****500.00	09-22-97

THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.

140316774	F	05/19-05/19/97	759.00	259.00	500.00
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* (CB123230) 19

AGENCY SCHEDULE NUMBER	0114970918
AGENCY TELEPHONE NUMBER	206-553-5508

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS (OR PHONE NUMBER) INDICATED ABOVE

C-1A

STATEMENT OF ACCOUNT
 For the period 10/30/96 Thru 05/04/99
 ANCH FRACTURE & ORTHO CLINIC
 3260 PROVIDENCE DR., SUITE 230
 ANCHORAGE, AK 99508
 907-563-3145
 TO: [REDACTED]
 WASILLA, AK 99654

Account# CB133924 Ins prov# Prov# IRS# 92-0039318
 Tel: 907- [REDACTED] Cht# 00CB133924 Birth: 10/28/57 SS#: [REDACTED]

DATE	PROV PL NAME	SERV	SERVICE DESCRIPTION	ICDA	AMOUNT
Claim # 1					
10/30/96 20	DO MARC	99203	NEW PATIENT OFFICE VISIT	92321	120.00
10/30/96 20	DO MARC	L3907	THUMB SPICA SPLINT	92321	44.50
10/30/96 20	DO MARC	7311022	WRIST X-RAYS (3V)	92321	84.00
10/30/96 20	DO MARC	73140	FINGER X-RAYS	92321	66.00
03/20/97 20	MARC	PWC	PAYMENT BY WORKERS' COMP		268.50-
			USDL		
06/30/98 20	MARC	CAKWC	ALASKA W/C FEE SCHEDULE		46.00-
*****TOTAL OF CLAIM TRANS *****					\$.00
Claim # 2					
11/06/96 20	DO MARC	99212	ESTABLISHED PATIENT VISI	3540	51.00
03/20/97 20	MARC	PWC	PAYMENT BY WORKERS' COMP		41.00-
			USDL		
06/30/98 20	MARC	CAKWC	ALASKA W/C FEE SCHEDULE		10.00-
*****TOTAL OF CLAIM TRANS *****					\$.00
Claim # 3					
12/04/96 20	DO MARC	99212	ESTABLISHED PATIENT VISI	72703	51.00
03/20/97 20	MARC	PWC	PAYMENT BY WORKERS' COMP		41.00-
			USDL		
06/30/98 20	MARC	CAKWC	ALASKA W/C FEE SCHEDULE		10.00-
*****TOTAL OF CLAIM TRANS *****					\$.00
Claim # 4					
01/15/97 20	DO MARC	99212	ESTABLISHED PATIENT VISI	72703	52.00
02/17/97 20	MARC	PWC	PAYMENT BY WORKERS' COMP		41.00-
			USDL		
02/25/97 20	MARC	COWC	OUT OF STATE FEE SCHEDULE		11.00-
*****TOTAL OF CLAIM TRANS *****					\$.00
Claim # 5					
01/27/97 20	DO MARC	99023	PRE-OP VISIT; ONE DAY PRI	72703	.00
*****TOTAL OF CLAIM TRANS *****					\$.00
Claim # 6					
03/30/97 20	OH MARC	26055	TENOAGINOTOMY, FINGER	72703	791.00
03/30/97 20	MARC	COWC	OUT OF STATE FEE SCHEDULE		336.00-
03/30/97 20	MARC	PWC	PAYMENT BY WORKERS' COMP		455.00-
			USDL		
*****TOTAL OF CLAIM TRANS *****					\$.00

C-15

United States Treasury 15-51 M 090,141,265

Check No. 2036 99386617

02 24 97 24 PHILADELPHIA, PA 2036 99386617
L920039318A4 M2 OWCP-MISC. 0114970220 16152001

Pay to the order of ANCHORAGE FRAC AND ORTHOPEDIC CLND1
3260 PROVIDENCE DRIVE NUM 200
ANCHORAGE AK 99508

\$****455*00
VOID AFTER ONE YEAR

PER ENCLOSED MAILING NOTICE

20361# :0000000518: 993866170# 010297

NOTICE TO CHECK RECIPIENT

TREASURY FINANCIAL MANAGEMENT SERVICE 775 FORM 808 (Rev.)

VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLND1
US DEPT OF LABOR, ESA/OWCP
1111 3RD AVE
SUITE 650
SEATTLE, WA, 98101-3211

VENDOR ID: L920039318A4
FINANCIAL CENTER: PHILADELPHIA, PA

CHECK NUMBER: 2036-99386617
CHECK AMOUNT: \$****455.00
CHECK DATE: 02-26-97

AGENCY SCHEDULE NUMBER: 0114970220
AGENCY TELEPHONE NUMBER: 206-553-5508

THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.

140318678
01/28-01/28/94 701.08 1736.00 155.00

NON NEGOTIABLE

CB133924 Clm 6

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS FOR TELEPHONE NUMBER INDICATED ABOVE.

C-16

-----S T A T E M E N T O F A C C O U N T-----

For the period 12/09/96 Thru 05/04/99
 ANCH FRACTURE & ORTHO CLINIC
 3260 PROVIDENCE DR., SUITE 200
 ANCHORAGE, AK 99508
 907-563-3145

Statement date: 05/06/99 KH PAGE 3
 TO: ~~PERSON~~, GARY L.
~~907-563-3145~~
 ANCHORAGE, AK 99514

Account# CB118635 Ins prov# Prov# IRS# 92-0039318
 Tel: 907-~~563-3145~~ Cht# 00CB118635 Birth: 02/06/50 SS#: ~~99-00-1234~~

DATE	PROV	PL NAME	SERV	SERVICE DESCRIPTION	ICDA	AMOUNT
03/28/97	45	GARY	COWC	OUT OF STATE FEE SCHEDUL		11.00-
*****TOTAL OF CLAIM TRANS *****						\$.00

Claim #	9					
02/25/97	65	DO GARY	99274	CONFIRMATORY CONSULTATIO	7220	235.00
04/09/97	65	GARY	PWC	PAYMENT BY WORKERS' COMP		175.00-
			USDL			
04/11/97	65	GARY	COWC	OUT OF STATE FEE SCHEDUL		60.00-
*****TOTAL OF CLAIM TRANS *****						\$.00

Claim #	10					
04/97	45	DO GARY	99023	PRE-OP VISIT; ONE DAY PRI	7261	.00
*****TOTAL OF CLAIM TRANS *****						\$.00

Claim #	11					
03/12/97	45	DO GARY	99024	POSTOPERATIVE FOLLOW UP	7261	.00
*****TOTAL OF CLAIM TRANS *****						\$.00


Claim #	12					
03/06/97	45	OH GARY	23420	REPAIR, SHOULDER CUFF AV	8404	3264.00
05/05/97	45	GARY	PWC	PAYMENT BY WORKERS' COMP		2099.00-
			USDL			
11/02/98	45	GARY	COWC	OUT OF STATE FEE SCHEDUL		1165.00-
*****TOTAL OF CLAIM TRANS *****						\$.00

Claim #	13					
04/02/97	45	DO GARY	99024	POSTOPERATIVE FOLLOW UP	7261	.00
*****TOTAL OF CLAIM TRANS *****						\$.00

Claim #	14					
10/29/97	45	DO GARY	99213	ESTABLISHED PATIENT VISI	8404	73.00
12/05/97	45	GARY	PWC	PAYMENT BY WORKERS' COMP		65.00-
			USDL			
12/97	45	GARY	COWC	OUT OF STATE FEE SCHEDUL		8.00-
*****TOTAL OF CLAIM TRANS *****						\$.00

C-17

United States Treasury 58-1 600 090,532,877

 Pay to the order of

04 28 97 59 PHILADELPHIA, PA 2038 50342599
 L920039318A2 R2 OWCP-MISC. 0114970424 161520U

ANCHORAGE FRAC AND ORTHOPEDIC CLND1
 3260 PROVIDENCE DRIVE NUM 200
 ANCHORAGE AK 99508

***2099*0

VOID AFTER ONE YEAR

PER ENCLOSED MAILING NOTICE

20383 0000000518 50342599 010497

NOTICE TO CHECK RECIPIENT TREASURY FINANCIAL MANAGEMENT SERVICE TFS FORM 5039 (Rev. 2)

<small>VENDOR NAME</small>	ANCHORAGE FRAC AND ORTHOPEDIC CLND1		<small>VENDOR ID NUMBER</small>	L920039318A2
<small>AGENCY NAME AND BILLING ADDRESS</small>	US DEPT OF LABOR, ESA/OWCP 1111 3RD AVE SUITE 680 SEATTLE, WA. 98101-3211	<small>U.S. TREASURY REG. FINANCIAL CENTER</small>	PHILADELPHIA, PA	
<small>CHECK NUMBER</small>	2038-50342599	<small>CHECK AMOUNT</small>	***2099.00	<small>CHECK DATE</small> 04-28-97
<small>THIS PAYMENT IS FOR FECA BILLS. NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.</small>		<small>FOLLOWING IS THE CASE NUMBER OR DATE, SERVICE ALC 16-15-2001</small>		
<small>PAYMENT IDENTIFICATION DATA</small>	140310333 G BARLOW 03/06-03/04/93	3,264.00-1,165.00-2,099.00		
NON NEGOTIABLE		<small>AGENCY SCHEDULE NUMBER</small> 0114970424 <small>AGENCY TELEPHONE NUMBER</small> 206-553-5111		

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS OR TELEPHONE NUMBER INDICATED ABOVE.

13

-----S T A T E M E N T O F A C C O U N T-----
 For the period 04/11/97 Thru 05/04/99
 ANCH FRACTURE & ORTHO CLINIC
 3260 PROVIDENCE DR., SUITE 200
 ANCHORAGE, AK 99508
 907-563-3145

Statement date: 05/06/99 KH PAGE 1
 TO: ~~XXXXXXXXXX~~ WALTER
~~XXXXXXXXXXXXXXXXXXXX~~
 NORTH POLE, AK 99705

Account# CA135805 Ins prov# Prov# IRS# 92-0039318
 Tel: 907-~~563-3145~~ Cht# CA135805 Birth: 03/12/55 SS#: ~~99-33-3026~~

DATE	PROV	PL NAME	SERV	SERVICE DESCRIPTION	ICDA	AMOUNT
Claim # 1						
04/11/97 20	DO	WALTER	9920357	NEW PATIENT OFFICE VISIT	81341	122.00
05/13/97 20		WALTER	PWC	PAYMENT BY WORKERS' COMP		65.00-
				USDL		
05/16/97 20		WALTER	COWC	OUT OF STATE FEE SCHEDUL		57.00-
*****TOTAL OF CLAIM TRANS *****						\$.00
Claim # 2						
04/14/97 20	OH	WALTER	(25620)	COLLES FRACTURE	81341	1758.00
03/97 20	DO	WALTER	99080	SPECIAL REPORTS OR FORMS		25.00
04/28/97 20	DO	WALTER	(73110)	WRIST XRAY (3V)	81341	86.00
05/29/97 20		WALTER	PWC	PAYMENT BY WORKERS' COMP		1227.00-
				USDL		
05/30/97 20		WALTER	COWC	OUT OF STATE FEE SCHEDUL		642.00-
*****TOTAL OF CLAIM TRANS *****						\$.00
Claim # 3						
04/28/97 20	DO	WALTER	99024	POSTOPERATIVE FOLLOW UP	81341	.00
*****TOTAL OF CLAIM TRANS *****						\$.00
Claim # 4						
06/06/97 20	DO	WALTER	99024	POSTOPERATIVE FOLLOW UP	81341	.00
*****TOTAL OF CLAIM TRANS *****						\$.00
Claim # 5						
06/06/97 20	DO	WALTER	73110	WRIST XRAY (3V)	81341	86.00
06/06/97 20	DO	WALTER	L3908	COCK-UP WRIST SPLINT	81341	20.50
07/14/97 20		WALTER	PWC	PAYMENT BY WORKERS' COMP		68.50-
				USDL		
08/15/97 20		WALTER	COWC	OUT OF STATE FEE SCHEDUL		38.00-
*****TOTAL OF CLAIM TRANS *****						\$.00
Claim # 6						
06/19/97 20	DO	WALTER	99080	SPECIAL REPORTS OR FORMS		25.00
07/23/97 20		WALTER	PWC	PAYMENT BY WORKERS' COMP		25.00-
				USDL		

(C-19)

United States Treasury 15-51
000 M 092,273,009

Check No. 05 27 97 6 PHILADELPHIA, PA 2038 29513514
L920039318A6 M2 OMCP-MISC. 0114970522 16152001

Pay to the order of ANCHORAGE FRAC AND ORTHOPEDIC CLN01
3250 PROVIDENCE DRIVE NUM 200
ANCHORAGE AK 99508 \$***1227*00
VOID AFTER ONE YEAR

PER ENCLOSED MAILING NOTICE

20383# 4000000518: 29513514# 010597

NOTICE TO CHECK RECIPIENT TREASURY FINANCIAL MANAGEMENT SERVICE TFS FORM 2039 (Rev.)

VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLN01	VENDOR I.D. NUMBER: L920039318A6
AGENCY NAME AND BILLING ADDRESS: US DEPT OF LABOR, ESA/OWCP 1111 3RD AVE SUITE 650 SEATTLE, WA. 98101-3211	CHECK NUMBER: 2038-29513514 CHECK AMOUNT: \$***1227.00 CHECK DATE: 05-27-97

THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.

140322506 U-135805-2
135805 04/18-04/28/97 788.00 904.00 124.00
135805 04/18-04/28/97 86.00 3.00 83.00
135805 04/18-04/28/97 86.00 3.00 83.00

AGENCY TELEPHONE NUMBER: 206-553-550

NON-NEGOTIABLE

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS OR TELEPHONE NUMBER INDICATED ABOVE

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AFOC

OFFICIAL
ALASKA
WORKERS' COMPENSATION
—◆— MEDICAL FEE SCHEDULE

MEDICODE

(D-1)

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Introduction

The Alaska Division of Workers' Compensation (ADWC) is pleased to announce the implementation of the *Official Alaska Workers' Compensation Medical Fee Schedule*, which provides the maximum reimbursement rates for practitioner and non-practitioner services. All fees contained in this schedule are effective for dates of service beginning on September 16, 1996.

Pursuant to *Alaska Administrative Code* 8 AAC 45.082(i)(3), the usual, customary, and reasonable fees were determined based on the 90th percentile of ranges of charges for similar services reported to Medicode. This schedule shall be used by insurance carriers, self-insurers, bill review organizations, and other payer organizations as a guide for approving and paying medical charges of physicians and surgeons and other health care providers for services rendered under the *Alaska Administrative Code*.

ORGANIZATION OF THE FEE SCHEDULE

The *Official Alaska Workers' Compensation Medical Fee Schedule* is comprised of two parts: Practitioner Services and Facilities Services combined as one schedule, and an additional Inpatient hospital schedule. The Practitioner and Outpatient Facility schedules are divided into the following sections: Evaluation and Management (E/M), Anesthesia, Surgery, Radiology, Pathology and Laboratory, Medicine, HCPCS (DME), and Pharmacy. Each of these sections are preceded by general guidelines pertinent to it. The schedule is divided into these sections for structural purposes only.

Providers are to use the section(s) that contain the procedure(s) they perform or the service(s) they render. This schedule utilizes *Physicians' Current Procedural Terminology* (CPT) codes. This schedule of fees represents the maximum level of medical and surgical reimbursement for the treatment of employment related injuries and/or illnesses, which the Alaska Workers' Compensation Board deems to be reasonable and necessary. Providers should bill their normal charges for services, not values listed within this schedule.

Familiarity with these general rules within the guidelines section as well as general guidelines within each section is necessary for all who use the schedule. It is extremely important that these be read before the schedule is used.

COLUMN HEADINGS AND INTERPRETING THE FEE SCHEDULE

The two-part data portion of the *Official Alaska Workers' Compensation Medical Fee Schedule* is arranged under easy-to-use column headings, which are explained below.

Practitioner (Provider) Schedule

For the purposes of this schedule, two categories are included within each section of the fee schedule: the Practitioner section and the Outpatient Facility section. Most healthcare services and procedures can be divided between two types of billings: the professional or physician services, and the services performed in an

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outpatient facility. The amounts in the Practitioner section of this fee schedule represent the physician portion of a service or procedure and are to be used by physicians or other certified or licensed providers who do not meet the definition of an outpatient facility (see Facility section below for an explanation of the Facility Schedule).

Some surgical, radiology, laboratory, and medicine services and procedures can be divided into two components — the professional and the technical. A professional service is one that must be rendered by a physician or other certified or licensed practitioner as defined by the State of Alaska working within the scope of their licensure. Both the professional and the total fee are included in the practitioner schedule. The difference between the total fee and the professional fee equals the technical fee for a procedure. If a physician has performed both the professional and the technical component of a procedure (both the reading or interpretation of the service, which includes a report, and the technical portion of the procedure), then he/she is entitled to the total value of the procedure identified as the Total Fee in this schedule. When billing for the total service only, the procedure code should be billed with no modifier. When billing for the professional component only, modifier -26 should be appended. When billing for the technical component only, modifier -27 should be appended.

The dollar amounts in the Outpatient Facility schedule are not to be used for physician reimbursement. Refer to the Outpatient Facility Schedule for a complete explanation.

Outpatient Facility Schedule

The Outpatient Facility Schedule represents services performed in an outpatient facility, billed on the UB-92 (HCFA-1450) claim form. This includes but is not limited to ambulatory surgical centers (ASC), hospitals, and free standing clinics within hospital property. Approximately 10 percent of data in the Outpatient Facility schedule reflects ASC charges. Only the types of facilities described above will be reimbursed using the Outpatient Facility schedule. Professional or physician services are not represented in the Outpatient facility schedule but are listed in the practitioner schedule. Only those charges that apply to the facility charges — not the professional service — are included in the Outpatient Facility schedule.

The amounts in the Facility Schedule represent the technical portion or component of a service or procedure. Typically, the technical component requires the use of specialized instrumentation or equipment but not necessarily the presence of a physician. Most facilities will be billing for the technical portion of a service only. Billings received on the UB-92 for an outpatient service are assumed to be for the technical portion only of the procedure. The reimbursement is listed in the Outpatient Facility schedule for the technical portion of a procedure. If the facility bills for the total component of a procedure (i.e. both the professional and technical component), the professional dollar amount from the Practitioner Schedule should be added to the Outpatient Facility dollar amount to reimburse the total component for the procedure. Hospitals must identify the services as the total component for correct reimbursement.

Implementation of the outpatient facility schedule

A revenue code is defined by the Health Care Financing Administration (HCFA) as a code which identifies a specific accommodation, ancillary service or billing calculation. Revenue codes are used by outpatient facilities to specify the type and place of service being billed and to reflect charges for items and services provided. A substantial number of outpatient facilities use both CPT codes and revenue codes to bill private payers for outpatient facility services. The Outpatient Facility fee schedule is driven by CPT code rather than revenue code. Common revenue codes are listed for components of the comprehensive surgical outpatient facility charge, as well as pathology and laboratory services, radiology services, and medicine services. This information is a guideline for producing a total surgical charge by bundling revenue code charges into one surgical CPT code.

Recommended Implementation Methodology

Many outpatient surgical facility bills consist of charges associated with both CPT and revenue center codes. The reimbursement amounts included in the Outpatient Facility fee schedule are listed for CPT codes only, they are organized as follows:

Procedure	CPT Codes
Surgical	10000-69979 (excluding 36400, 36405, 36406, 36415 (G0001), 36600)

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Nonsurgical 36400, 36405, 36406, 36415, 36600, 70010-99499

Use the following methodology to combine the charges billed in conjunction with revenue center codes billed on a UB-92 and determine the appropriate CPT code:

1. Select nonsurgical CPT codes (as defined above) on a line item basis.
2. For a single surgical procedure, combine all remaining charges associated with any of the following revenue center codes into the charge associated with the single surgical CPT code:

Surgical Procedures

250-252,257-258	39X	76X
26X	45X	79X
270-272,276	49X	
360-361	70K	
370	71X	
38X	75X	

Note: Revenue code 76X (treatment or observation room) may appear on an outpatient facility UB-92 for an outpatient stay of up to 24 hours. The total fee includes up to 3 hours of observation services. Observation services over 3 hours may be billed/reimbursed an additional fee.

3. If multiple surgical procedures are billed, bundle all charges as described in step 2. Allow 100% of the billed charge or fee allowance (whichever is lowest) for the highest relative valued procedure. Subsequent surgical procedures are allowed at 50% of the fee allowance or billed charge (whichever is lowest)

Outpatient Facility Surgical Revenue Code Matrix

REV CODE	DESCRIPTION	COMBINE
250	Pharmacy	Yes
258	IV Solution	Yes
27X	Medical/Surgical Supplies	Yes
300	Laboratory	***
310	Pathology	***
320	Radiology	***
36X (360-361)	Operating Room Services	Yes
37X (370)	Anesthesia	Yes
38X (381)	Blood	Yes

39X (390)	Blood Storage and Processing	Yes
41X (410)	Respiratory Services	***
49X (490)	Ambulatory Surgery	Yes
71X (710)	Recovery Room	Yes
75X (750)	Gastro-intestinal Services	Yes
76X (760)	Treatment or Observation Room	Yes

*** Radiology CPT codes (70010-79999), Laboratory and Pathology CPT codes (80002-88399), and Medicine Services (90700-99199) are not combined. Determine fee allowance on a code-by-code basis for these CPT codes.

Implementation Methodology Examples

Example 1

84153 PSA
84630 Zinc

Each of these nonsurgical CPT codes should be reviewed individually to determine the outpatient facility fee allowance.

Example 2

93510 Left heart catheterization
36415 Routine venipuncture
85025 Blood count; CBC

All three CPT codes are should be reviewed individually to determine the outpatient fee allowance.

Example 3

258 IV solutions
370 Anesthesia
42820 Tonsillectomy and adenoidectomy

Combine revenue codes 258 and 370 into the charge for surgical CPT code 42820. Use 42820 to determine the outpatient facility fee allowance.

Example 4

258 IV solutions
272 Sterile supply
370 Anesthesia
381 Blood/PKD red
27784 Open treatment of proximal fibula
36415 Routine Venipuncture

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Combine revenue codes 258, 272, 370, and 381 into the charge for surgical CPT code 27784. Use both CPT codes 28285 and 36415 to determine outpatient facility fee allowances.

Example 5

30006 Automated multichannel test
31000 Urinalysis
49505 Inguinal hernia repair

In this example, use three CPT codes to determine outpatient facility fee allowances.

Procedures Not Performed in an Outpatient Facility

Many procedures (specifically surgical procedures) are not performed in an outpatient setting, accounting for approximately 25 percent of all surgical procedures. These procedures are identified with a subcode of NF (Not Outpatient Facility procedure) in the relative value table.

Surgical Services

Outpatient facility services directly related to the procedure on the day of an outpatient surgery comprise the comprehensive, or all-inclusive, surgical outpatient facility charge. The comprehensive outpatient surgical facility charge usually includes the following services:

Anesthesia administration materials and supplies

- Blood, blood plasma, platelets, etc.
- Drugs and biologicals
- Equipment, devices, appliances, and supplies
- Use of the outpatient facility
- Nursing and related technical personnel services
- Surgical dressings, splinting, and casting materials

An outpatient is defined as a person who presents to a medical facility for services and is released on the same day. Observation patients are considered outpatients because they are not admitted to the hospital.

Drugs and Biologicals

Drugs and biologicals are considered an integral portion of the comprehensive surgical outpatient fee allowance. This category includes drugs administered immediately prior to or during an outpatient facility procedure and

administered in the recovery room or other designated area of the outpatient facility.

Example

Intravenous (IV) solutions, Narcotics, Antibiotics and Steroids

Revenue Center 25X: Pharmacy

Revenue Code	Standard Abbreviation
250	Pharmacy (general classification)
251	Drugs/generic
252	Drugs/nongeneric
257	Drugs/nonprescript
258	IV solutions
259	Drugs/other

Drugs and biologicals for take-home use (self-administration) by the patient are not included in the outpatient facility fee allowance, use the pharmacy section in the Alaska Fee Schedule.

Equipment, Devices, Appliances, and Supplies

All equipment, devices, appliances, and general supplies commonly furnished by an outpatient facility for a surgical procedure are incorporated into the comprehensive outpatient facility fee allowance.

Example

Syringe for drug administration
Patient gown
IV pump

Revenue Center 27X: Medical/Surgical Supplies

Revenue Code	Standard Abbreviation
270	Med-surg supplies
272	Sterile supplies

Specialty and Limited-Supply Items

Particular surgical techniques or procedures performed in an outpatient facility require certain specialty and limited-supply items that may or may not be included in the comprehensive outpatient facility fee allowance. This is because the billing patterns vary for different outpatient facilities.

These items should be supported by an invoice from the supplier showing the actual cost incurred by the

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outpatient facility for the purchase of the supply item or device.

Durable Medical Equipment (DME)

The sale, lease, or rental of durable medical equipment for use in a patient's home is not included in the comprehensive surgical outpatient facility fee allowance.

Example

Unna boot for a postoperative podiatry patient.
Crutches for a patient with a fractured tibia.

Use of Outpatient Facility and Ancillary Services

The comprehensive surgical outpatient fee allowance includes outpatient facility patient preparation areas, the operating room, recovery room, and any ancillary areas of the outpatient facility such as a waiting room or other area used for patient care. Specialized treatment areas, such as a GI (gastrointestinal) lab, Cath (cardiac catheterization) lab, cast room, free-standing clinic, treatment or observation room, or other facility areas used for outpatient care are also included. Other outpatient facility and ancillary service areas included as an integral portion of the comprehensive surgical outpatient facility fee allowance are all general administrative functions necessary to run and maintain the outpatient facility. These functions include but are not limited to administration and record keeping, security, housekeeping, and plant operations.

Nursing and Related Technical Personnel Services

Patient care provided by nurses and other related technical personnel is included in the comprehensive surgical outpatient facility fee allowance. This category includes services performed by licensed nurses, nurses' aides, orderlies, technologists, and other related technical personnel employed by the outpatient facility.

Surgical Dressings, Splinting, and Casting Materials

Certain outpatient facility procedures involve the application of a surgical dressing, splint, or cast in the operating room or similar area by the physician. The types of surgical dressings, splinting, and casting materials commonly furnished by an outpatient facility are considered part of the comprehensive surgical outpatient facility fee allowance.

FORMAT OF THE FEE SCHEDULE

The fee schedule columns are different in each of the sections. Listed below are all column titles that you will find throughout the fee schedule.

Code

This first column is the American Medical Association's *Physicians' Current Procedural Terminology* (CPT) five-digit code number, 1996 edition. New codes in CPT 1996 are designated by a ● symbol, and codes with changed descriptive nomenclature are identified by the ▲ symbol. CPT codes changed or altered for use in this schedule are identified with an ®.

Starred Procedures

Starred (*) procedures, indicating that the usual "package" concept does not apply and that associated pre- and postoperative services are not included in the code as described, are indicated by a * in this column.

Refer to the complete description in CPT 1996, page 57, for a comprehensive explanation of starred procedures or the surgery section within this fee schedule.

Description (Nomenclature)

The *Official Alaska Workers' Compensation Medical Fee Schedule* uses actual CPT 1996 descriptions that have been abbreviated to 48 characters. If you have any questions regarding the descriptions as they appear, please consult the 1996 *Physicians' Current Procedural Terminology*.

Total Fee

This column lists the total fee assigned to each procedure. There are, however, procedures with no fee assigned to them. When this is the case, one of the following designations will appear in the total fee column:

BR	Indicates a "By Report" procedure, which is typically one that is too variable to accept a set relative value.
NC	Indicates codes that are considered non-covered procedures by the ADWC under Alaska workers' compensation law.
NF	Indicates services or procedures not usually performed in an outpatient surgical facility.

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PS	Indicates a professional service or procedure and refers you to the Provider Schedule.	amount; use modifier -26 to report these services.
TF	Indicates procedures that are not normally billed as a total component by a physician but usually billed by a facility. This field is informational only.	FUD ("Global" Period) This column lists the follow-up days, sometimes referred to as the "global period" of a service or procedure. In Alaska, it includes the day of the surgery through termination of the postoperative period.
Total Fee	This manual lists the total reimbursable as a monetary amount. There are, however, procedures too variable to accept a set value — these are "By Report" procedures and are noted BR.	ASST This column indicates whether or not a surgical procedure is commonly expected to require the services of an assistant surgeon.
PC Fee	Where there is an identifiable physician and technical component, the portion considered to be the physician component (PC) is listed. The physician component gives the total reimbursable as a monetary	OUTPT FEE This manual lists the total reimbursable as a monetary amount for outpatient facility services. There are, however, procedures too variable to accept a set value — these are "By Report" procedures and are noted BR.

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Adjustment Factors for Services Outside of Alaska

The State of Alaska requires that reimbursement be specific to the area in which the service was performed. Listed below are Geographic Adjustment Factors (GAF) designed to convert the Alaska Allowables to allowables for 86 additional areas nationwide. Multiply the GAF corresponding to the geographical area where the service(s) were performed to obtain the area-specific allowable.

Alabama.....	0.757	Florida.....	Pompano Beach.....	0.838
Arizona.....	0.800	Florida.....	Orlando.....	0.823
Arizona.....	Phoenix.....	Florida.....	Tampa-St. Petersburg	
Arkansas.....	0.835		Clearwater.....	0.821
Arkansas.....	0.734	Georgia.....		0.826
California.....	0.887	Georgia.....	Atlanta.....	0.868
California.....	Los Angeles-Anaheim	Hawaii.....		0.940
	Santa Ana-Riverside-San Bernardino-Long	Idaho.....		0.785
	Beach.....	Illinois.....		0.773
	Oxnard-Ventura.....	Illinois.....	Chicago-Lake County	
California.....	1.078		Aurora-Elgin-Joliet.....	0.942
California.....	Sacramento.....	Indiana.....		0.726
California.....	0.900	Indiana.....	Indianapolis.....	0.792
California.....	San Diego.....	Indiana.....	Gary-Hammond.....	0.942
California.....	0.943	Iowa.....		0.720
California.....	San Francisco-Oakland	Kansas.....		0.703
	San Jose-Santa Cruz.....	Kansas.....	Kansas City.....	0.787
	Santa Rosa-Petaluma.....	Kentucky.....		0.746
	Vallejo-Fairfield-Napa.....			
Colorado.....	1.013			
Colorado.....	0.780			
Colorado.....	Denver-Boulder.....			
	Longmont.....			
Connecticut.....	0.881			
Connecticut.....	1.035			

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Louisiana.....	0.783	Ohio.....	Cleveland-Akron-Lorain.....	0.837	
Louisiana.....	New Orleans.....	0.868	Ohio.....	Elyria.....	0.786
Maine.....	0.823	Oklahoma.....	Columbus.....	0.788	
Maryland.....	0.793	Oregon.....		0.742	
Maryland.....	Baltimore.....	0.957	Oregon.....	Portland.....	0.782
Maryland.....	Washington DC suburbs.....	1.002	Pennsylvania.....		0.850
Massachusetts.....	0.956	Pennsylvania.....	Pittsburgh-Beaver Valley.....	0.891	
Massachusetts.....	Boston-Lawrence-Salem-Lowell-Brockton		Pennsylvania.....	Philadelphia.....	1.048
	1.006	Rhode Island.....		0.943	
Michigan.....	0.800	South Carolina.....		0.737	
Michigan.....	Detroit-Ann Arbor.....	0.909	South Carolina.....	Rock Hill.....	0.847
Minnesota.....	0.862	South Dakota.....		0.687	
Minnesota.....	Minneapolis-St. Paul.....	0.835	Tennessee.....		0.804
Mississippi.....	0.717	Texas.....		0.803	
Missouri.....	0.680	Texas.....	Dallas-Fort Worth		
Missouri.....	Kansas City.....	0.787		Arlington.....	0.811
Missouri.....	St. Louis.....	0.798	Texas.....	Houston-Galveston	
Montana.....	0.732		Brazoria-Texas City.....	0.881	
Nebraska.....	0.684	Texas.....	San Antonio.....	0.782	
Nevada.....	0.933	Utah.....		0.708	
New Hampshire.....	0.859	Utah.....	Salt Lake City-Ogden.....	0.725	
New Jersey.....	1.024	Vermont.....		0.805	
New Jersey.....	Bergen-Passaic-Jersey City	Virginia.....		0.821	
	Middlesex-Somerset	Virginia.....	Norfolk-Virginia Beach		
	Hunterdon-Monmouth		Newport News.....	0.823	
	Ocean-Newark.....	Virginia.....	Washington DC suburbs.....	1.002	
New Jersey.....	Trenton-Vineland	Washington.....		0.783	
	Millville-Bridgeton.....	Washington.....	Seattle-Tacoma.....	0.830	
New Mexico.....	0.808	Washington.....	Vancouver.....	0.782	
New York.....	0.840	West Virginia.....		0.806	
New York.....	Buffalo-Niagara Falls.....	Wisconsin.....		0.806	
New York.....	New York-Nassau-Suffolk	Wisconsin.....	Kenosha.....	0.942	
	Orange County.....	Wisconsin.....	Milwaukee-Racine.....	0.867	
New York.....	Rochester.....	Wyoming.....		0.714	
North Carolina.....	0.780				
North Carolina.....	Charlotte-Gastonia.....				
North Dakota.....	0.807				
Ohio.....	0.755				
Ohio.....	Cincinnati-Hamilton-Middletown.....				
	0.768				

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Surgery

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Surgery

10040 - 69979

Medical Fee Schedule

CODE	DESCRIPTION	TOTAL FEE	PC FEE	FUD	ASST	OUTPT FEE
20902	BONE GFT ANY DONOR AREA: MAJOR/LARGE	1381.76		090	Y	10072.20
20910	CARTILAGE GFT: COSTOCHONDRAL	1018.14		090	N	6043.32
20912	CARTILAGE GFT: NASAL SEPTUM	1199.95		045	N	4028.88
20920	FASCIA LATA GFT: BY STRIPPER	799.96		045	N	3021.66
20922	FASCIA LATA GFT: INCS & AREA EXPOSURE COMPLEX	1090.86		045	Y	4028.88
20924	TENDON GFT FROM A DISTANCE	763.60		045	Y	8057.76
20926	TISS GFT OTHER	727.24		045	N	8057.76
● 20930	ALLOGFT SPINE SURG ONLY: MORSELIZED	418.16		000	N	IP
● 20931	ALLOGFT SPINE SURG ONLY: STRUCTURAL	509.07		000	N	IP
● 20936	AUTOGFT SPINE SURG ONLY: LOCAL THRU SAME INCIS	636.34		000	Y	IP
● 20937	AUTOGFT SPINE SURG ONLY: MORSELIZED	1109.04		000	Y	IP
● 20938	AUTOGFT SPINE SURG ONLY: STRUCTUR/BI-TRICORTICAL	1381.76		000	Y	IP
20950	MONITOR INTERSTITIAL PRESS-DETECT MUSCL COMPARTM	254.53		000	N	IP
20955	BONE GFT W/MICROVASCULAR ANASTOM: FIBULA	5454.30		045	Y	IP
20960	BONE GFT W/MICROVASCULAR ANASTOM: RIB	5454.30		045	Y	IP
20962	BONE GFT W/MICROVASC ANASTOM: OTHER BONE GFT	6363.35		045	Y	IP
20969	FREE OSTEOCUT FLAP: NOT ILIAC CREST/RIB/METATARS	7272.40		045	Y	IP
20970	FREE OSTEOCUT FLAP W/MICROVASC ANASTOM: ILIAC	7272.40		045	Y	IP
20971	FREE OSTEOCUT FLAP W/MICROVASCULAR ANASTOM: RIB	7272.40		045	Y	IP
20972	FREE OSTEOCUT FLAP W/MICROVASC ANASTOM: METATARS	7272.40		045	Y	8057.76
20973	FREE OSTEOCUT FLAP W/MICROVASC ANASTOM: GRT TOE	7745.11		045	Y	8057.76
20974	ELEC STIM TO AID BONE HEALING: NONINVASIVE	909.05		000	N	IP
20975	ELEC STIM TO AID BONE HEALING: INVASIVE	1454.48		000	Y	BR
20999	UNLISTED PROC MS SYST GEN	BR		000	Y	BR
21010	ARTHROTOMY TEMPOROMANDIBULAR JT	3510.20		090	N	4235.45
21015	RADICAL RESECT TUMOR SOFT TISS FACE/SCLP	BR		090	Y	4235.45
21025	EXC BONE: MANDIB	2329.04		090	N	5445.58
21026	EXC BONE: FACIAL BONE	2495.40		090	N	4840.51
21029	REMOV BY CONTOURING BEN TUMOR FACIAL BONE	2794.85		090	N	5445.58
21030	EXC BEN TUMOR/CYST FACE BONE OTHER THAN MANDIB	1563.78		090	N	4235.45
21031	EXC TORUS MANDIBULARIS	583.92		090	N	4537.98
21032	EXC MAXIL TORUS PALATINUS	831.80		090	N	4537.98
21034	EXC MALIG TUMOR FACIAL BONE OTHER THAN MANDIB	2761.58		090	Y	5445.58
21040	EXC BEN CYST/TUMOR MANDIB: SIMPL	765.26		090	N	3630.38
21041	EXC BEN CYST/TUMOR MANDIB: COMPLEX	1530.51		090	Y	5445.58
21044	EXC MALIG TUMOR MANDIB	2761.58		090	Y	4840.51
21045	EXC MALIG TUMOR MANDIB: RADICAL RESECT	4990.80		090	Y	IP
21050	CONDYLECTOMY TEMPOROMANDIBULAR JT (SEPART PROC)	3992.64		090	N	3630.38
21060	MENISCECTOMY PART/COMPLT TMJ (SEPART PROC)	4491.72		090	Y	4235.45
21070	CORONOIDECTOMY (SEPART PROC)	3293.93		090	N	3630.38
● 21076	IMPRESSION & CUSTOM PREP: SURG OBTRUR PROSTH	2561.94		015	N	IP

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Surgery

10040 - 69979

Medical Fee Schedule

CODE	DESCRIPTION	TOTAL FEE	PC FEE	FUD	ASST	OUTPT FEE
21820	CLO TX STERNUM FX	481.23		045	N	1210.13
21825	OPEN TX STERNUM FX W/MO SKELETAL FIXA	1924.90		090	Y	IP
21899	UNLISTED PROC NECK/THORAX	8R		000	Y	8R
21920	BX SOFT TISS BACK/FLANK: SUPERF	259.86		015	N	339.38
21925	BX SOFT TISS BACK/FLANK: DEEP	923.95		015	N	3016.74
21930	EXC TUMOR SOFT TISS BACK/FLANK	1462.92		015	N	3016.74
21935	RADICAL RESECT TUMOR SOFT TISS BACK/FLANK	3272.33		045	N	4223.44
▲ 22100	PART EXC POST VERTEB COMPN-1 SEGMT: CERV	1732.41		090	Y	3620.09
▲ 22101	PART EXC POST VERTEB COMPN-1 SEGMT: THOR	1732.41		090	Y	3620.09
▲ 22102	PART EXC POST VERTEB COMPN-1 SEGMT: LUMB	1732.41		090	Y	3620.09
● 22103	PART EXC POST VERTEB COMPN: EA ADD SEGMT	519.72		000	Y	IP
▲ 22110	PART EXC VERTEB BODY W/O DECOMP-1 SEGMT: CERV	2309.88		090	Y	IP
▲ 22112	PART EXC VERTEB BODY W/O DECOMP-1 SEGMT: THOR	2309.88		090	Y	IP
▲ 22114	PART EXC VERTEB BODY W/O DECOMP-1 SEGMT: LLMB	2309.88		090	Y	IP
● 22116	PART EXC VERTEB BODY: EA ADD VERTEB SEGMT	692.96		000	Y	IP
▲ 22210	OSTEOT SPINE-POST/POSTLAT APPROACH-1 SEGMT: CERV	6814.15		090	Y	IP
▲ 22212	OSTEOT SPINE-POST/POSTLAT APPROACH-1 SEGMT: THOR	6621.66		090	Y	IP
▲ 22214	OSTEOT SPINE-POST/POSTLAT APPROACH-1 SEGMT: LUMB	6737.15		090	Y	IP
● 22216	OSTEOT SPINE-POST/POSTLAT APPROACH: EA ADD SEGMT	2021.15		000	Y	IP
▲ 22220	OSTEOT SPINE W/DISSECT-ANT APPROCH-1 SEGMT: CERV	7199.13		090	Y	IP
▲ 22222	OSTEOT SPINE W/DISSECT-ANT APPROCH-1 SEGMT: THOR	7006.64		090	Y	IP
▲ 22224	OSTEOT SPINE W/DISSECT-ANT APPROCH-1 SEGMT: LUMB	7122.13		090	Y	IP
● 22226	OSTEOT SPINE W/DISSECT-ANT APPROCH: EA ADD SEGMT	2136.64		000	Y	IP
22305	CLO TX VERTEBRAL PROCESS FX	500.47		045	N	502.79
▲ 22310	CLO TX VERTEB BODY FX W/O MANIP-W/CAST/BRACE	1058.70		090	N	1206.70
▲ 22315	CLO TX VERT FX/DISLOC W/CAST/BRACE-BY MANIP/TRAC	1539.92		090	N	2413.39
▲ 22325	OPEN TX VERT FX/DISLOC-VIA POST-1 SEGMT: LUMB	4427.27		090	Y	IP
▲ 22326	OPEN TX VERT FX/DISLOC-VIA POST-1 SEGMT: CERV	4812.25		090	Y	IP
▲ 22327	OPEN TX VERT FX/DISLOC-VIA POST-1 SEGMT: THOR	4619.76		090	Y	IP
● 22328	OPEN TX VERT FX/DISLOC VIA POST: EA ADD VERT/SEG	1385.93		000	Y	IP
22505	MANIP SPINE REQUIRING ANES ANY REGION	442.73		015	N	553.07
▲ 22548	ARTHRORHESIS-ANT-C1 C2, W/MO EXC ODONTOID PROCESS	5337.29		090	Y	IP
▲ 22554	ARTHRORHESIS-ANT W/MINI DISSECT: CERV-BELOW C2	5156.36		090	Y	IP
▲ 22556	ARTHRORHESIS-ANT INTERBODY W/MINI DISSECT: THOR	5699.14		090	Y	IP
▲ 22558	ARTHRORHESIS-ANT INTERBODY W/MINI DISSECT: LUMB	5156.36		090	Y	IP
▲ 22585	ARTHRORHESIS-ANT-W/MINI DISSECT: EA ADD INTRSPACE	1546.91		000	Y	IP
▲ 22590	ARTHRORHESIS-POST TECH. CRANIOCERV	5880.06		090	Y	IP
▲ 22595	ARTHRORHESIS-POST TECH. ATLAS-AXIS	5988.62		090	Y	IP
▲ 22600	ARTHRORHESIS-POST/POSTLAT-1 LEVEL: CERV BELOW C2	5156.36		090	Y	IP
▲ 22610	ARTHRORHESIS-POST/POSTLAT-1 LEVEL: THOR	4794.51		090	Y	IP
▲ 22612	ARTHRORHESIS-POST/POSTLAT-1 LEVEL: LUMB	4667.87		090	Y	IP

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Medical Fee Schedule

CODE	DESCRIPTION	TOTAL FEE	PC FEE	FUD	ASST	OUTPT FEE
● 22614	ARTHRODESIS-POST/POSTLAT TECH: EA ADD VERT SEGMT	1555.96		000	Y	IP
▲ 22630	ARTHRODESIS-POST INTERBODY-1 INTERSPACE: LUMB	4523.13		090	Y	IP
● 22632	ARTHRODESIS-POST INTERBODY: EA ADD INTERSPACE	1501.68		000	Y	IP
▲ 22800	ARTHRODESIS-POST-W/MO CAST; 6/LESS VERTEB SEGMT	6241.91		090	Y	IP
▲ 22802	ARTHRODESIS-POST-W/MO CAST; 7 TO 12 VERTEB SEGMT	7490.30		090	Y	IP
● 22804	ARTHRODESIS-POST-W/MO CAST; 13/MORE VERTEB SEGMT	8991.97		090	Y	IP
● 22808	ARTHRODESIS-ANT-W/MO CAST; 2 TO 3 VERTEB SEGMT	6006.71		090	Y	IP
▲ 22810	ARTHRODESIS-ANT-W/MO CAST; 4 TO 7 VERTEB SEGMT	7237.00		090	Y	IP
▲ 22812	ARTHRODESIS-ANT-W/MO CAST; 8/MORE VERTEB SEGMT	8394.92		090	Y	IP
22830	EXPLOR SPINAL FUSION	5789.60		090	Y	IP
▲ 22840	POST NON-SEGMENT INSTRUM	3347.11		090	Y	IP
● 22841	INT SPINAL FIX BY WIRING SPINOUS PROCESSES	180.93		000	Y	IP
▲ 22842	POST SEGMENT INSTRUM: 3 TO 6 VERTEB SEGMT	4161.28		090	Y	IP
● 22843	POST SEGMENT INSTRUM: 7 TO 12 VERTEB SEGMT	4577.40		090	Y	IP
● 22844	POST SEGMENT INSTRUM: 13/MORE VERTEB SEGMT	5029.72		090	Y	IP
▲ 22845	ANT INSTRUM: 3 VERTEB SEGMT	4342.20		090	Y	IP
● 22846	ANT INSTRUM: 4 TO 7 VERTEB SEGMT	4776.42		090	Y	IP
● 22847	ANT INSTRUM: 8/MORE VERTEB SEGMT	5246.83		090	Y	IP
● 22848	PCLV FIX OTH THAN SACRUM	BR		000	Y	IP
22849	REINSERTION SPINAL FIXA DEVICE	3437.58		090	Y	IP
22850	REMOV POST NONSEGMENTAL INSTRUM	2352.03		090	Y	IP
● 22851	APPLIC PROSTH DEVICE TO VERTEB DEFECINTERSPACE	1990.18		000	Y	IP
22852	REMOV POST SEGMENT INSTRUM	2713.88		090	Y	IP
22855	REMOV ANT INSTRUM	4523.13		090	Y	IP
22899	UNLISTED PROC SPINE	BR		000	Y	BR
22900	EXC ABD WALL TUMOR SUBFASCIAL	1013.18		045	Y	3620.09
22999	UNLISTED PROC ABD MS SYST	BR		000	Y	BR
23000	REMOV SUBDELTOID CALCAREOUS DEPOSITS OPEN METHOD	998.34		045	Y	4223.44
23020	CAPSULAR CONTRACTURE RELEASE (SEVER TYPE PROC)	1996.68		045	Y	4826.78
23030	I&D SHOULDER AREA: DEEP ABSCESS/HEMATOMA	665.56		015	N	3620.09
23031	I&D SHOULDER AREA: INFEC BURSA	665.56		015	N	3620.09
23035	INCS DEEP W/OPEN CORTEX SHOULDER AREA	1331.12		045	Y	4223.44
23040	ARTHROTOMY GLENOHUMERAL JT W/EXPLOR-REMOV FB	1896.85		090	Y	4223.44
23044	ARTHROTOMY AC/STERNOCCLAV JT W/EXPLOR-REMOV FB	1164.73		090	N	5430.13
23065	BX SOFT TISS SHOULDER AREA: SUPERF	232.95		015	N	301.67
23066	BX SOFT TISS SHOULDER AREA: DEEP	698.84		015	N	3620.09
23075	EXC TUMOR SHOULDER AREA: SUBQ	565.73		015	N	3016.74
23076	EXC TUMOR SHOULDER AREA: DEEP SUBFASCIAL/M	1131.45		015	N	4223.44
23077	RADICAL RESECT TUMOR SOFT TISS SHOULDER AREA	7154.77		045	Y	4826.78
23100	ARTHROTOMY W/BX GLENOHUMERAL JT	1663.90		090	Y	4223.44
23101	ARTHROTOMY W/BX/EXC TORN CARTILAGE-AC/SC JT	1763.73		090	N	6033.48

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Medical Fee Schedule

CODE	DESCRIPTION	TOTAL FEE	PC FEE	FUD	ASST	OUTPT FEE
23105	ARTHROTOMY W/SYNOVECTOMY: GLENOHUMERAL JT	2995.02		090	Y	4826.78
23106	ARTHROTOMY W/SYNOVECTOMY: STERNOCLAVICULAR JT	1996.68		090	N	4826.78
23107	ARTHROTOMY-GLENOHUMERAL JT W/EXPLOR W/WO REMOV	2196.35		090	Y	5430.13
23120	CLAVICULECTOMY: PART	1663.90		090	Y	6636.83
23125	CLAVICULECTOMY: TOT	2662.24		090	Y	IP
23130	ACROMIOPLASTY/ACROMIONECTOMY PART	1663.90		090	N	7240.18
23140	EXC/CURET BONE CYST/BEN TUMOR CLAV/SCAPULA	1031.62		045	N	4223.44
23145	EXC/CURET BONE CYST/TUMOR CLAV/SCAP: W/AUTOGFT	1547.43		090	Y	6033.48
23146	EXC/CURET BONE CYST/TUMOR CLAV/SCAP: W/ALLOGFT	1331.12		090	N	4826.78
23150	EXC/CURET BONE CYST/BEN TUMOR PROX HUMERUS	1996.68		045	Y	4223.44
23155	EXC/CURET BONE CYST/TUMOR PROX HUMERUS: W/AUTOGFT	2495.85		090	Y	6033.48
23156	EXC/CURET BONE CYST/TUMOR PROX HUMERUS: W/ALLOGFT	2163.07		090	Y	4826.78
23170	SEQUESTRECTOMY CLAV	1497.51		090	N	4826.78
23172	SEQUESTRECTOMY SCAPULA	1996.68		045	Y	4826.78
23174	SEQUESTRECTOMY HUMERAL HEAD TO SURG NECK	3327.80		090	Y	4826.78
23180	PART EXC BONE CLAV	1364.40		090	N	6033.48
23182	PART EXC BONE SCAPULA	1331.12		090	N	6033.48
23184	PART EXC BONE PROX HUMERUS	1996.68		090	N	6033.48
23190	OSTECTOMY SCAPULA PART	1081.54		045	N	6033.48
23195	RESECT HUMERAL HEAD	2662.24		090	Y	6033.48
23200	RADICAL RESECT TUMOR: CLAV	1996.68		090	Y	IP
23210	RADICAL RESECT TUMOR: SCAPULA	3327.80		090	Y	IP
23220	RADICAL RESECT TUMOR PROX HUMERUS	3327.80		090	Y	IP
23221	RADICAL RESECT TUMOR PROX HUMERUS: W/AUTOGFT	3993.36		090	Y	IP
23222	RAD RESECT TUMOR PROX HUMERUS: W/PROSTH REPLAC	3993.36		090	Y	IP
23330	REMOV FB SHOULDER: SUBQ	199.67		015	N	2413.39
23331	REMOV FB SHOULDER: DEEP	998.34		045	N	4223.44
23332	REMOV FB SHOULDER: COMPLIC INCL TOT SHOULDER	3660.58		090	Y	IP
23350	INJ PROC SHOULDER ARTHROGRAPHY	166.39		000	N	251.40
23395	MUSCL TRANSF ANY TYPE SHOULDER/UPPER ARM: SNGL	3327.80		090	Y	5430.13
23397	MUSCL TRANSF ANY TYPE SHOULDER/UPPER ARM: MX	8R		090	Y	IP
23400	SCAPULOPEXY	3327.80		090	Y	5430.13
23405	TENOMYOTOMY SHOULDER AREA: SNGL	1663.90		090	Y	5430.13
23406	TENOMYOTOMY SHOULDER AREA: MX THRU SAME INCS	2163.07		090	Y	6033.48
23410	REPR RUPT MUSCULOTENDINOUS CUFF: ACUTE	2512.49		090	Y	5430.13
23412	REPR RUPT MUSCULOTENDINOUS CUFF: CHRONIC	2995.02		090	Y	6033.48
23415	CORACOACROMIAL LIG RELEASE W/WO ACROMIOPLASTY	1730.46		090	N	5430.13
23420	REPR COMPLT SHOULDER CUFF AVULSION CHRONIC	3826.97		090	Y	7240.18
23430	TENODESIS LONG TENDON BICEPS	2262.90		090	Y	5430.13
23440	RESECT/TRANSPL LONG TENDON BICEPS	1996.68		090	Y	6033.48
23450	CAPSULORRHAPHY ANT: PUTTI-PLATT/MAGNUSON TYPE	3128.13		090	Y	6033.48

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Medical Fee Schedule

CODE	DESCRIPTION	TOTAL FEE	PC FEE	FUD	ASST	OUTPT FEE
25505	CLO TX RADIAL SHAFT FX: W/MANIP	814.80		090	N	2413.39
25515	OPEN TX RADIAL SHAFT FX W/WO INT/EXT FIXA	1773.39		090	N	4826.78
25520	CLO TX RADIAL SHAFT FX W/DISLOC DIST RAD-ULNA JT	814.80		045	N	2413.39
25525	OPEN TX RAD SHAFT FX W/FIXA & CLO TX RADULNAR JT	2076.95		090	Y	4826.78
25526	OPEN TX RAD SHAFT FX W/FIX & OPEN TX RADULNAR JT	2396.48		090	Y	5430.13
25530	CLO TX ULNAR SHAFT FX: WO MANIP	511.25		045	N	1206.70
25535	CLO TX ULNAR SHAFT FX: W/MANIP	766.87		090	N	2413.39
25545	OPEN TX ULNAR SHAFT FX W/WO INT/EXT FIXA	1773.39		090	Y	4826.78
25560	CLO TX RADIAL & ULNAR SHAFT FX: WO MANIP	639.06		045	N	1206.70
25565	CLO TX RADIAL & ULNAR SHAFT FX: W/MANIP	1214.21		090	N	2413.39
25574	OPEN TX RADIAL & ULNAR SHAFT FX W/FIX: RAD/ULNA	2364.52		090	Y	4826.78
25575	OPEN TX RAD & ULNA SHAFT FX W/FIX: RADIUS & ULNA	2586.19		090	Y	5430.13
25600	CLO TX DIST RAD FX W/WO FX ULNA STYLOID: WO MANI	551.19		045	N	1810.04
25605	CLO TX DIST RAD FX W/WO FX ULNA STYLOID: W/MANIP	846.75		090	N	2413.39
25611	PERCUT FIX DISTAL RAD FX W/WO FX ULNA W/MANIP	1437.89		090	Y	3016.74
25620	OPEN TX DISTAL RAD FX W/WO FX ULNA W/WO FIXA	1725.46		090	Y	4826.78
25622	CLO TX CARPAL SCAPHOID FX: WO MANIP	591.13		045	N	1206.70
25624	CLO TX CARPAL SCAPHOID FX: W/MANIP	766.87		090	N	2413.39
25628	OPEN TX CARPAL SCAPHOID FX W/WO INT/EXT FIXA	1661.56		090	Y	4826.78
25630	CLO TX CARPAL BONE FX: WO MANIP EA BONE	487.28		045	N	1206.70
25635	CLO TX CARPAL BONE FX: W/MANIP EA BONE	796.83		090	N	2413.39
25645	OPEN TX CARPAL BONE FX EA BONE	1198.24		090	Y	4826.78
25650	CLO TX ULNAR STYLOID FX	702.97		045	N	1206.70
25660	CLO TX RADIO-INTERCARPAL DISLOC 1/MORE W/MANIP	796.83		090	N	2413.39
25670	OPEN TX RADIOCARPAL/INTERCARP DISLOC 1/MORE BONE	1597.65		090	Y	4826.78
25675	CLO TX DISTAL RADIOULNAR DISLOC W/MANIP	639.06		045	N	2413.39
25676	OPEN TX DISTAL RADIOULNAR DISLOC ACUTE/CHRONIC	1278.12		090	Y	4826.78
25680	CLO TX TRANS-SCAPHOPERILUNAR FX DISLOC W/MANIP	1134.33		090	N	3620.09
25685	OPEN TX TRANS-SCAPHOPERILUNAR TYPE FX DISLOC	2172.80		090	Y	4826.78
25690	CLO TX LUNATE DISLOC W/MANIP	956.59		090	N	2413.39
25695	OPEN TX LUNATE DISLOC	1949.13		090	Y	4826.78
25800	ARTHRODESIS WRIST JT: WO BONE GFT	1981.09		090	Y	6033.48
25805	ARTHRODESIS WRIST JT: W/SLIDING GFT	2396.48		090	Y	7240.18
25810	ARTHRODESIS WRIST JT: W/ILIAC/OTHER AUTOGFT	2747.96		090	Y	7240.18
25820	INTERCARPAL FUSION: WO BONE GFT	2300.62		090	Y	6033.48
25825	INTERCARPAL FUSION: W/AUTOGFT	3131.39		090	Y	7240.18
25830	ARTHRODESIS RADIOULNAR JT-RESECT ULNA-WWO BON GFT	2556.24		090	Y	7240.18
25900	AMPUTA FOREARM THRU RADIUS & ULNA	1917.18		090	Y	IP
25905	AMPUTA FOREARM THRU RADIUS & ULNA: OPEN CIRCULAR	1661.56		090	Y	IP
25907	AMPUTA FOREARM: SECNDRY CLOSURE REVIS	734.92		045	Y	4826.78
25909	AMPUTA FOREARM THRU RADIUS & ULNA: RE-AMPUTA	1917.18		090	Y	IP

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Medical Fee Schedule

CODE	DESCRIPTION	TOTAL FEE	PC FEE	FUD	ASST	OUTPT FEE
25915	KRUKENBERG PROC	2140.85		090	Y	IP
25920	DISART THRU WRIST	1917.18		090	Y	IP
25922	DISART THRU WRIST; SECNDRY CLOS/SCAR REVIS	639.06		045	Y	4826.78
25924	DISART THRU WRIST; RE-AMPUTA	1917.18		090	Y	IP
25927	TRANSMETACARPAL AMPUTA	1917.18		090	N	IP
25929	TRANSMETACARPAL AMPUTA; SECNDRY CLOS/SCAR REVIS	639.06		045	Y	4826.78
25931	TRANSMETACARPAL AMPUTA; RE-AMPUTA	1917.18		090	N	IP
25999	UNLISTED PROC FOREARM/WRIST	BR		000	Y	BR
26010	DRAINAGE FINGER ABSCESS: SIMPL	159.07		000	N	201.12
26011	DRAINAGE FINGER ABSCESS: COMPLIC	596.52		000	N	2413.39
26020	DRAINAGE TENDON SHEATH 1 DIGIT & OR PALM	1193.04		015	N	3620.09
26025	DRAINAGE PALMAR BURSA: SNGL ULNAR/RADIAL	1193.04		015	N	2413.39
26030	DRAINAGE PALMAR BURSA: MX/COMPLIC	2783.76		015	N	3620.09
26034	INCS DEEP W/OPEN BONE CORTEX HAND/FINGER	1272.58		045	N	4826.78
26035	DECOMP FINGERS & OR HAND INJ INJURY	2783.76		090	N	6033.48
26037	DECOMP FASCIOTOMY HAND	1193.04		045	N	6033.48
26040	FASCIOTOMY PALMAR DUPUYTREN'S CONTRACTURE: CLO	835.13		045	N	6033.48
26045	FASCIOTOMY PALMAR DUPUYTREN'S CONTRCT: OPEN PART	1193.04		045	N	5430.13
26055	TENDON SHEATH INCS	1033.97		045	N	4826.78
26060	TENOTOMY SUBQ SNGL EA DIGIT	516.98		015	N	4223.44
26070	ARTHROTOMY-INFEC W/EXPLOR: CARPOMETACARPAL JT	1193.04		090	N	3620.09
26075	ARTHROTOMY-INFEC W/EXPLOR-DRAIN-REMOV FB: MCP JT	1193.04		045	N	5430.13
26080	ARTHROTOMY-INFEC W/EXPLOR-DRAIN-IP JT EA	954.43		045	N	5430.13
26100	ARTHROTOMY W/SYNOVIAL BX: CARPOMETACARPAL JT	1193.04		090	N	3620.09
26105	ARTHROTOMY W/SYNOVIAL BX: MCP JT	994.20		045	N	2413.39
26110	ARTHROTOMY W/SYNOVIAL BX: IP JT EA	835.13		045	N	2413.39
26115	EXC TUMOR/VASCUL MALFORM HAND/FINGER: SUBQ	795.36		015	N	3016.74
26116	EXC TUMOR/VASCULAR MALFORM HAND/FINGER: DEEPM	1272.58		015	N	3620.09
26117	RADICAL RESECT TUMOR SOFT TISS HAND/FINGER	4175.64		045	N	4826.78
26121	FASCIECTOMY PALMAR ONLY W/WO Z-PLASTY/SKIN GFT	2584.92		045	N	6033.48
26123	FASCIECTOMY PALMAR: PART PALMAR EXC W/REL 1 DIGIT	2982.60		045	N	3016.74
26125	FASCIECTOMY PALMAR: PART PALM EXC: EA ADD DIGIT	994.20		000	N	4826.78
26130	SYNOVECTOMY CARPOMETACARPAL JT	1789.56		090	N	5430.13
26135	SYNOVECTOMY MCP JT INCL RELEAS & RECON EA DIGIT	1590.72		090	Y	4826.78
26140	SYNOVECTOMY PROX IP JT INCL RECON EA IP JT	1391.88		090	N	4826.78
26145	SYNOVECTOMY RADICAL FLEXOR PALM/FINGER SNGL EA	1590.72		090	N	4826.78
26160	EXC LES TENDON SHEATH/CAPSULE HAND/FINGER	914.66		015	N	3620.09
26170	EXC TENDON PALM FLEXOR SNGL (SEPART PROC) EA	994.20		045	N	4826.78
26180	EXC TENDON FINGER FLEXOR (SEPART PROC)	994.20		045	N	4826.78
26200	EXC/CURET BONE CYST/BEN TUMOR METACARPAL	1193.04		045	N	3620.09
26205	EXC/CURET BONE CYST/TUMOR METACARPAL: W/AUTO GFT	1590.72		090	N	4826.78

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Medical Fee Schedule

CODE	DESCRIPTION	TOTAL FEE	PC FEE	FUD	ASST	OUTPT FEE
63005	LAMINECT W/EXPLOR 1-2 VERTEB; LUMBAR EX SPONDYLO	4066.34		090	Y	IP
63011	LAMINECTOMY W/EXPLOR 1-2 VERTEB SEGMENT; SACRAL	4578.39		090	Y	IP
63012	LAMINECT W/REMOV ABNL FACETS-SPONDYLOLIST LUMBAR	4819.36		090	Y	IP
63015	LAMINECTOMY W/EXPLOR > 2 VERTEBRAL SEGMENT; CERV	5180.81		090	Y	IP
63016	LAMINECT W/EXPLOR > 2 VERTEBRAL SEGMENT; THORACIC	5421.78		090	Y	IP
63017	LAMINECTOMY W/EXPLOR > 2 VERTEBRAL SEGMENT; LUMBAR	5180.81		090	Y	IP
63020	LAMINOTOMY W/DECOMP NERV ROOT; 1 INTERSPACE CERV	4759.12		090	Y	IP
63030	LAMINOT W/DECOMP NERV ROOT; 1 INTERSPACE LUMBAR	4608.51		090	Y	IP
63035	LAMINOT W/DECOMP; EA ADD INTERSPACE CERV/LUMBAR	1506.05		000	Y	IP
63040	LAMINOTOMY W/DECOMP NERV ROOT RE-EXPLOR; CERV	5180.81		090	Y	IP
63042	LAMINOTOMY W/DECOMP NERV ROOT RE-EXPLOR; LUMBAR	5391.66		090	Y	IP
63045	LAMINECTOMY SNGL VERTEBRAL SEGMENT; CERV	5722.99		090	Y	IP
63046	LAMINECTOMY SNGL VERTEBRAL SEGMENT; THORACIC	5572.39		090	Y	IP
63047	LAMINECTOMY SNGL VERTEBRAL SEGMENT; LUMBAR	5572.39		090	Y	IP
63048	LAMINECTOMY 1 SEGMENT; EA ADD CERV/THORACIC/LUMBAR	1807.26		000	Y	IP
63055	TRANSPEDICULAR APPROACH SNGL SEGMENT; THORACIC	6174.81		090	Y	IP
63056	TRANSPEDICULAR APPROACH SNGL SEGMENT; LUMBAR	5662.75		090	Y	IP
63057	TRANSPEDICULAR APPROACH SNGL SEGMENT; EA ADD SEGMENT	2048.23		000	Y	IP
63064	COSTOVERTEBRAL W/DECOMP THORACIC; SNGL SEGMENT	5180.81		090	Y	IP
63066	COSTOVERTEBRAL W/DECOMP THORACIC; EA ADD SEGMENT	1716.90		000	Y	IP
63075	DISCECTOMY ANT W/DECOMP; CERV SNGL INTERSPACE	4759.12		090	Y	IP
63076	DISCECTOMY ANT W/DECOMP; CERV EA ADD INTERSPACE	1506.41		000	Y	IP
63077	DISCECTOMY ANT W/DECOMP; THORACIC 1 INTERSPACE	4518.15		090	Y	IP
63078	DISCECTOMY ANT; THORACIC EA ADD INTERSPACE	1506.05		000	Y	IP
63081	VERTEBRAL CORPECTOMY-ANT W/DECOMP; CERV 1 SEGMENT	5722.99		090	Y	IP
63082	VERTEBRAL CORPECTOMY-ANT; CERV EA ADD SEGMENT	1897.62		000	Y	IP
63085	VERTEBRAL CORPECT TRANS THORACIC; THORACIC 1 SEGMENT	5722.99		090	Y	IP
63086	VERTEBRAL-CORPECT TRANS THOR; THORACIC EA ADD SEGMENT	1897.62		000	Y	IP
63087	VERTEBRAL CORPECTOMY LOW THORACIC/LUMBAR; 1 SEGMENT	5482.02		090	Y	IP
63088	VERTEBRAL CORPECTOMY LOW THORACIC/LUMBAR; EA ADD	1837.38		000	Y	IP
63090	VERTEBRAL CORPECTOMY TRANSFERUTON LUMB/SACRAL; 1	5421.78		090	Y	IP
63091	VERTEBRAL CORPECTOMY LUMB/SACRAL; EA ADD SEGMENT	1807.26		000	Y	IP
63170	LAMINECTOMY W/MYELOTOMY CERV/THORACIC/THORACOLUM	4578.39		090	Y	IP
63172	LAMINECTOMY W/DRAIN CYST; TO SUBARACHNOID SPACE	5060.33		090	Y	IP
63173	LAMINECTOMY W/DRAIN CYST; TO PERITONEAL SPACE	5572.39		090	Y	IP
63180	LAMINECTOMY & SECT DENTATE LIGAMENT CERV; 1-2 SEG	4578.39		090	Y	IP
63182	LAMINECTOMY & SECT DENTATE LIGAMENT CERV; >2 SEGMENT	5482.02		090	Y	IP
63185	LAMINECTOMY W/RHIZOTOMY; 1 OR 2 SEGMENT	4578.39		090	Y	IP
63190	LAMINECTOMY W/RHIZOTOMY; MORE THAN 2 SEGMENT	5482.02		090	Y	IP
63191	LAMINECTOMY W/SECT SPINAL ACCESS NERV	4096.46		090	Y	IP
63194	LAMINECTOMY W/SECT 1 SPINOTHALMIC TRACT; CERV	3840.43		090	Y	IP

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Surgery

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Surgery

10040 - 69979

Medical Fee Schedule

CODE	DESCRIPTION	TOTAL FEE	PC FEE	FUD	ASST	OUTPT FEE
64510 *	INJ ANES AGENT: STELLATE GANGLION	544.68		000	N	844.30
64520 *	INJ ANES AGENT: LUMBAR/THORACIC	505.78		000	N	1266.44
64530 *	INJ ANES AGENT: CELIAC PLEXUS W/VO RAD MONITOR	641.95		000	N	1477.52
64550	APPLIC SURFACE NEUROSTIMULATOR	136.17		000	N	123.13
64553	PERCUT IMPLNT NEUROSTIM ELECTRODES: CRANIAL NERV	311.25		000	N	281.43
64555	PERCUT IMPLNT NEUROSTIM ELECTRODES: PERIPHERAL	311.25		000	N	281.43
64560	PERCUT IMPLNT NEUROSTIM ELECTRODES: AUTONOMIC	311.25		000	N	281.43
64565	PERCUT IMPLNT NEUROSTIM ELECTRODES: NEUROMUSCUL	311.25		000	N	281.43
64573	INCS IMPLNT NEUROSTIM ELECTRODES: CRANIAL NERV	389.06		000	N	351.79
64575	INCS IMPLNT NEUROSTIM ELECTRODES: PERIPHERAL	466.87		000	N	422.15
64577	INCS IMPLNT NEUROSTIM ELECTRODES: AUTONOMIC	466.87		000	N	422.15
64580	INCS IMPLNT NEUROSTIM ELECTRODES: NEUROMUSCULAR	466.87		000	Y	422.15
64585	REVIS/REMOV PERIPHERAL NEUROSTIMULATOR ELECTRODE	466.87		000	Y	422.15
64590	INCS & SUBQ PL/CMT PERIPHERAL NEUROSTIM PULSE GEN	466.87		000	Y	422.15
64595	REVIS/REMOV PERIPHERAL NEUROSTIM PULSE GEN	389.06		000	Y	351.79
64600	DESTRUCT TRIGEMINAL: SUPRAORBITAL/INFRAORBITAL	395.61		015	N	369.38
64605	DESTRUCT TRIGEMINAL: 2ND & 3RD DIV @ FORAMEN OVAL	565.16		015	N	1266.44
64610	DESTRUCT TRIGEMINAL: 2ND & 3RD DIV W/RADIOLOGIC	640.51		015	N	1266.44
64612	DESTRUCT: MUSCL ENERVATED BY FACIAL NERV	640.51		015	N	1266.44
64613	DESTRUCT BY NEUROLYTIC AGENT: CERV SPINAL MUSCL	640.51		015	N	1266.44
64620	DESTRUCT BY NEUROLYTIC AGENT: INTERCOSTAL NERV	310.84		015	N	290.23
64622	DESTRUCT: PARAVERTEB FACET JT NERV LUMBAR-1 LEVEL	508.64		015	N	1688.59
64623	DESTRUCT: FACET JT NERV LUMBAR EA ADD LEVEL	282.58		000	N	263.84
64630	DESTRUCT BY NEUROLYTIC AGENT: PUDENDAL NERV	508.64		015	N	1266.44
64640	DESTRUCT: OTHER PERIPHERAL NERV/BRANCH	339.09		015	N	316.61
64680	DESTRUCT CELIAC PLEXUS W/VO RAD MONITOR	452.12		015	N	422.15
64702	NEUROPLASTY: DIGITAL 1: BOTH SAME DIGIT	1130.31		090	N	1688.59
64704	NEUROPLASTY: NERV HAND/FT	1356.37		090	Y	1688.59
64708	NEUROPLSTY MAJ PERIPHR NERV ARM/LEG: NOT SPECIF	2260.62		090	Y	3377.18
64712	NEUROPLASTY MAJ PERIPHERAL NERV ARM/LEG: SCIATIC	2637.39		090	Y	3377.18
64713	NEUROPLASTY MAJ PERIPHERAL NERV: BRACHIAL PLEXUS	2788.10		090	Y	3799.33
64714	NEUROPLASTY MAJ PERIPHERAL NERV: LUMBAR PLEXUS	2072.24		090	Y	3377.18
64716	NEUROPLASTY &/OR TRANSPOSITION: CRANIAL NERV	2449.01		090	Y	3799.33
64718	NEUROPLASTY &/OR TRANSPOSIT: ULNAR NERV @ ELBOW	2449.01		090	N	3377.18
64719	NEUROPLASTY &/OR TRANSPOSIT: ULNAR NERV @ WRIST	1638.95		090	N	3377.18
64721	NEUROPLASTY &/OR TRANSP: MEDIAN @ CARPAL TUNNEL	1733.14		090	N	2532.89
64722	DECOMP: UNSPECIFIED NERV (SPECIFY)	1733.14		090	N	1688.59
64726	DECOMP: PLANTAR DIGITAL NERV	753.54		090	N	1688.59
64727	INT NEUROLYSIS REQUIRING USE OR MICRO	8R		000	N	8R
64732	TRANSECTION/AVULSION SUPRAORBITAL NERV	1130.31		045	Y	2532.89
64734	TRANSECTION/AVULSION INFRAORBITAL NERV	1130.31		045	N	2953.04

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Radiology

70010 - 79999

Medical Fee Schedule

CODE	DESCRIPTION	TOTAL FEE	PC FEE	OUTPT FEE
72074	RAD EXAM SPINE; THORACIC COMPLT W/OBLIQ MINI 4	174.34	69.74	221.29
72080	RAD EXAM SPINE; THORACOLUMBAR AP & LAT	147.67	59.07	187.44
72090	RAD EXAM SPINE; SCOLIOSIS STUDY W/SUPINE & ERECT	174.34	69.74	221.29
72100	RAD EXAM SPINE LUMBOSACRAL: AP & LAT	133.32	53.33	169.22
72110	RAD EXAM SPINE LUMBOSACRAL: COMPLT W/OBLIQ VIEWS	194.85	77.94	247.32
72114	RAD EXAM SPINE LUMBOSACRAL: COMPLT INCL BENDING	246.12	98.45	312.41
72120	RAD EXAM SPINE LUMBOSACRAL BENDING ONLY MINI 4	190.74	76.30	242.12
72125	CAT CERV SPINE: WO CONTRAST	861.67	258.50	1014.30
72126	CAT CERV SPINE: W/CONTRAST	981.20	264.92	1204.50
72127	CAT CERV SPINE: WO CONTRAST THEN W/CONTRAST	1179.22	294.81	1487.25
72128	CAT THORACIC SPINE: WO CONTRAST	861.67	258.50	1014.30
72129	CAT THORACIC SPINE: W/CONTRAST	981.20	264.92	1204.50
72130	CAT THORACIC SPINE: WO CONTRAST THEN W/CONTRAST	1179.22	294.81	1487.25
72131	CAT LUMBAR SPINE: WO CONTRAST	861.67	258.50	1014.30
72132	CAT LUMBAR SPINE: W/CONTRAST	981.20	264.92	1204.50
72133	CAT LUMBAR SPINE: WO CONTRAST THEN W/CONTRAST	1179.22	294.81	1487.25
72141	MRI SPINAL CANAL & CONTENTS CERV; WO CONTRAST	1471.80	294.36	1980.00
72142	MRI SPINAL CANAL & CONTENTS CERV; W/CONTRAST	1821.46	364.29	2450.40
72146	MRI SPINAL CANAL & CONTENTS THORACIC; WO CONTRAST	1605.60	321.12	2160.00
72147	MRI SPINAL CANAL & CONTENTS THORACIC; W/CONTRAST	1766.16	353.23	2376.00
72148	MRI SPINAL CANAL & CONTENTS LUMBAR; WO CONTRAST	1525.32	305.06	2052.00
72149	MRI SPINAL CANAL & CONTENTS LUMBAR; W/CONTRAST	1742.97	348.59	2344.80
72156	MRI SPINAL CANAL WO THEN W/CONTRAST CERV	2122.96	424.59	2856.00
72157	MRI SPINAL CANAL WO THEN W/CONTRAST; THORACIC	2185.40	437.08	2940.00
72158	MRI SPINAL CANAL WO THEN W/CONTRAST; LUMBAR	2071.22	414.24	2786.40
72159	MRI ANGIO SPINAL CANAL & CONTENTS W/WO CONTRAST	1898.18	379.64	2553.60
72170	RAD EXAM PELVIS: ANTEROPOSTERIOR ONLY	101.69	40.68	102.60
72190	RAD EXAM PELVIS: COMPLT MINI 3 VIEWS	128.45	51.38	129.60
72192	CAT PELVIS; WO CONTRAST	720.74	216.22	848.40
72193	CAT PELVIS; W/CONTRAST	820.64	221.57	1007.40
72194	CAT PELVIS; WO CONTRAST THEN W/CONTRAST	991.90	247.98	1251.00
72196	MRI PELVIS	1505.70	301.14	2025.60
72198	MRI ANGIO PELVIS W/WO CONTRAST MAT	1846.44	369.29	2484.00
72200	RAD EXAM SACROILIAC IT; LESS THAN 3 VIEWS	107.04	42.82	108.00
72202	RAD EXAM SACROILIAC IT; 3/MORE VIEWS	126.66	50.66	127.80
72220	RAD EXAM SACRUM & COCCYX MINI 2 VIEWS	108.82	43.53	109.80
72240	MYELOGRAPHY CERV-RAD S & I	570.88	199.81	624.00
72255	MYELOGRAPHY THORACIC-RAD S & I	531.63	186.07	581.10
72265	MYELOGRAPHY LUMBOSACRAL-RAD S & I	560.18	196.06	612.30
72270	MYELOGRAPHY ENTIRE SPINAL CANAL-RAD S & I	752.85	263.50	822.90
72285	DISKOGRAPHY CERV-RAD S & I	897.35	314.07	980.85
72295	DISKOGRAPHY LUMBAR-RAD S & I	847.40	296.59	926.25

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Radiology

70010 - 79999

Medical Fee Schedule

CODE	DESCRIPTION	TOTAL FEE	PC FEE	OUTPT FEE
73000	RAD EXAM: CLAV COMPLT	127.97	51.19	136.23
73010	RAD EXAM: SCAPULA COMPLT	134.16	53.66	142.82
73020	RAD EXAM SHOULDER: 1 VIEW	113.32	45.41	120.85
73030	RAD EXAM SHOULDER: COMPLT MINI 2 VIEWS	144.48	57.79	153.80
73040	RAD EXAM SHOULDER ARTHROGRAPHY-RAD S & I	385.97	135.09	445.12
73050	RAD EXAM: ACROMIOCLAV JT BILAT W/WO WT DISTRACT	127.97	51.19	136.23
73060	RAD EXAM: HUMERUS MINI 2 VIEWS	119.71	47.88	127.44
73070	RAD EXAM ELBOW: ANTEROPOSTERIOR & LAT VIEWS	107.33	42.93	114.25
73080	RAD EXAM ELBOW: COMPLT MINI 3 VIEWS	119.71	47.88	127.44
73085	RAD EXAM ELBOW ARTHROGRAPHY-RAD S & I	379.78	132.92	437.98
73090	RAD EXAM: FOREARM ANTEROPOSTERIOR & LAT VIEWS	103.20	41.28	109.86
73092	RAD EXAM: UPPER EXTREM INFANT MINI 2 VIEWS	109.39	43.76	116.45
73100	RAD EXAM WRIST: ANTEROPOSTERIOR & LAT VIEWS	94.94	37.98	101.07
73110	RAD EXAM WRIST: COMPLT MINI 3 VIEWS	107.33	42.93	114.25
73115	RAD EXAM WRIST ARTHROGRAPHY-RAD S & I	272.45	95.36	314.20
73120	RAD EXAM HAND: 2 VIEWS	97.01	38.80	103.27
73130	RAD EXAM HAND: MINI 3 VIEWS	107.33	42.93	114.25
73140	RAD EXAM FINGER(S) MINI 2 VIEWS	81.53	32.61	86.79
73200	CAT UPPER EXTREM: WO CONTRAST	833.86	250.16	1035.61
73201	CAT UPPER EXTREM: W/CONTRAST	949.44	256.35	1229.70
73202	CAT UPPER EXTREM: WO CONTRAST THEN W/CONTRAST	1147.58	286.90	1527.05
73220	MRI UPPER EXTREM OTHER THAN JT	1744.08	348.82	2475.51
73221	MRI ANY JT UPPER EXTREM	1700.74	340.15	2413.99
73225	MRI ANGIO UPPER EXTREM W/WO CONTRAST MAT	1839.02	367.80	2610.27
73500	RAD EXAM HIP: UNILAT 1 VIEW	99.05	39.62	108.45
73510	RAD EXAM HIP: COMPLT MINI 2 VIEWS	122.82	49.13	134.48
73520	RAD EXAM HIPS BILAT MIN 2 VIEWS W/AP VIEW PELVIS	158.48	63.39	173.52
73525	RAD EXAM HIP ARTHROGRAPHY-RAD S & I	370.45	129.66	439.40
73530	RAD EXAM HIP DURING OR PROC	164.42	65.77	180.03
73540	RAD EXAM PELVIS & HIPS INFANT/CHILD MINI 2 VIEWS	134.71	53.88	147.49
73550	RAD EXAM FEMUR ANTEROPOSTERIOR & LAT VIEWS	118.86	47.54	130.14
73560	RAD EXAM KNEE: ANTEROPOSTERIOR & LAT VIEWS	108.96	43.58	119.30
73562	RAD EXAM KNEE: AP & LAT W/OBLIQ MINI 3 VIEWS	128.77	51.51	140.99
73564	RAD EXAM KNEE: INCL OBLIQ & TUNNEL &/OR PATELLAR	144.61	57.84	158.34
73565	RAD EXAM KNEE: BOTH KNEES STANDING AP	108.96	43.58	119.30
73580	RAD EXAM KNEE ARTHROGRAPHY-RAD S & I	438.78	153.92	521.64
73590	RAD EXAM: TIB & FIB AP & LAT VIEWS	118.86	47.54	130.14
73592	RAD EXAM: LOWER EXTREM INFANT MINI 2 VIEWS	118.86	47.54	130.14
73600	RAD EXAM ANK: ANTEROPOSTERIOR & LAT VIEWS	106.97	42.79	117.13
73610	RAD EXAM ANK: COMPLT MINI 3 VIEWS	114.90	45.96	125.80
73615	RAD EXAM ANK ARTHROGRAPHY-RAD S & I	364.50	127.58	432.35
73620	RAD EXAM FT: ANTEROPOSTERIOR & LAT VIEWS	110.94	44.38	121.46

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Evaluation and Management

99201-99499

Medical Fee Schedule

CODE	DESCRIPTION	TOTAL FEE	OUTPAT FEE
99201	OFFIC/OUTPT VISIT E&M NEW SELF LIMIT/MINOR 10MIN	79.11	PS
99202	OFFIC/OUTPT VISIT E&M NEW LOW-MOD SEVERITY 20MIN	98.60	PS
99203	OFFIC/OUTPT VISIT E&M NEW MODERAT SEVERITY 30MIN	128.41	PS
99204	OFFIC/OUTPT VISIT E&M NEW MOD-HI SEVERITY 45 MIN	183.44	PS
99205	OFFIC/OUTPT VISIT E&M NEW MOD-HI SEVERITY 60 MIN	247.64	PS
99211	OFFIC/OUTPT VISIT E&M ESTAB NO PHYS PRES 5 MIN	46.97	PS
99212	OFFIC/OUTPT VISIT E&M EST SELF-LIMIT/MINOR 10MIN	66.74	PS
99213	OFFIC/OUTPT VISIT E&M EST LOW-MOD SEVERITY 15MIN	85.28	PS
99214	OFFIC/OUTPT VISIT E&M EST MOD-HI SEVERITY 25 MIN	123.60	PS
99215	OFFIC/OUTPT VISIT E&M ESTAB MOD-HI SEVRTY 40 MIN	197.76	PS
99217	OBSRV CARE D/C DA MGMT	131.16	PS
99218	INIT OBSRV CARE-DA E&M LOW SEVERITY	163.95	PS
99219	INIT OBSRV CARE-DA E&M MODERATE SEVERITY	222.97	PS
99220	INIT OBSRV CARE-DA E&M HIGH SEVERITY	279.81	PS
99221	INIT HOSP CARE-DA E&M LOW SEVERITY 30 MIN	182.53	PS
99222	INIT HOSP CARE-DA E&M MODERATE SEVERITY 50 MIN	245.93	PS
99223	INIT HOSP CARE-DA E&M HIGH SEVERITY 70 MIN	301.67	PS
99231	SUBSQT HOSP CARE-DA E&M STABLE/RECOVER 15 MIN	96.18	PS
99232	SUBSQT HOSP CARE-DA E&M MINOR COMPLIC 25 MIN	131.16	PS
99233	SUBSQT HOSP CARE-DA E&M SIGNIFIC COMPLIC 35 MIN	193.46	PS
▲ 99238	HOSP D/C DA MGMT; 30 MIN/LESS	113.67	PS
● 99239	HOSP D/C DA MGMT; MORE THAN 30 MIN	142.09	PS
99241	OFFIC CONS NEW/ESTAB SELF LIMIT/MINOR 15 MIN	124.68	PS
99242	OFFIC CONS NEW/ESTAB LOW SEVERITY 30 MIN	158.97	PS
99243	OFFIC CONS NEW/ESTAB MODERATE SEVERITY 40 MIN	202.61	PS
99244	OFFIC CONS NEW/ESTAB MOD-HIGH SEVERITY 60 MIN	264.95	PS
99245	OFFIC CONS NEW/ESTAB MOD-HIGH SEVERITY 80 MIN	334.56	PS
99251	INIT INPT CONS NEW/ESTAB SELF LIMIT/MINOR 20 MIN	147.54	PS
99252	INIT INPT CONS NEW/ESTAB LOW SEVERITY 40 MIN	189.10	PS
99253	INIT INPT CONS NEW/ESTAB MODERATE SEVERITY 55MIN	232.74	PS
99254	INIT INPT CONS NEW/ESTAB MOD-HI SEVERITY 80 MIN	290.92	PS
99255	INIT INPT CONS NEW/ESTAB MOD-HI SEVERITY 110 MIN	365.73	PS
99261	F/U INPT CONS ESTAB STABLE/RECOVER 10 MIN	78.96	PS
99262	F/U INPT CONS ESTAB MINOR COMPLIC 20 MIN	124.68	PS
99263	F/U INPT CONS ESTAB SIGNIF COMPLIC 30 MIN	180.79	PS
99271	CONFIRM CONS NEW/ESTAB SELF LIMIT/MINOR	124.68	PS
99272	CONFIRM CONS NEW/ESTAB LOW SEVERITY	158.97	PS
99273	CONFIRM CONS NEW/ESTAB MODERATE SEVERITY	202.61	PS
99274	CONFIRM CONS NEW/ESTAB MED DECISION MOD COMPLEX	264.95	PS
99275	CONFIRM CONS NEW/ESTAB MED DECISION HI COMPLEX	334.56	PS
99281	ER DEPT VISIT E&M SELF LIMITED/MINOR	78.12	PS

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Customized Fee Analyzer

CUSTOMIZED REPORT FOR:

ANCHORAGE FRACTURE

ORTHOPEDIC SURGERY

December 15, 1997

MEDICODE

5225 Wiley Post Way, Suite 500
Salt Lake City, Utah 84116-2889

E-1

#489668-U1297D1097

1 Introduction

Medicode welcomes you as a *Customized Fee Analyzer* client. The following pages describe the data we have compiled and various ways to use it. Medicode offers this data solely as a tool to help you evaluate your fees. You should not simply select a given percentile and assume that column will translate into an appropriate fee schedule. For example, if the financial and marketing goals of your practice call for mid-range fees, compare your current fee schedule to the area's 50th percentile. You may find several charges that fall well below the area's 50th percentile requiring gradual adjustment up to a more acceptable level. However, other fees may exceed the 75th percentile and require adjustment downward. The resulting fee schedule diminishes your patient's out-of-pocket expenses while placing your new charges in the "safety zone" for acceptance and payment by most commercial and managed care payers.

In addition to the fee and relative value data, each *Customized Fee Analyzer* includes a table of professional (PC) and technical (TC) component splits, and a table of commercial payer follow-up days, anesthesia unit values, and the necessity of surgical assists for all CPT codes. This data has been developed by the Medicode team of clinicians, coders, and payer representatives.

If you have questions about how to use this product, please call the Medicode Helpline at 800-765-6818. For those occasions when a code you want falls outside the ranges found in your *Analyzer*, your purchase price includes one phone call to receive additional fee information for a maximum of 10 codes. Please have your codes ready when you place your call.

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Customized Fee Analyzer Applications

This new edition of the *Analyzer* provides in-depth information to help evaluate your fee schedule. Useful applications include:

- A comparison of your current charges to those of other physicians in your area, now at three percentiles – 50th, 75th, and 95th.
- A comparison of your charges to a range of estimated national allowables paid by indemnity carriers.
- Identification of allowable charge errors on explanations of benefits from third-party payers.
- Development of fees for new or seldom-performed procedures.
- Modification of current fees, that are either too high or too low, with relative values.
- Identification of new CPT procedure codes of interest to your specialty or changes to descriptions from previous editions.

Using the Analyzer Format

The *Analyzer* cross-references CPT codes to Medicode's relative value study, to three percentiles (50th, 75th, 95th) of the specified area's prevailing fees, and to average national allowables paid by indemnity carriers. Reading across the top from left to right, the specific information provided in this product is as follows:

CPT Code – This column lists procedural codes from the 1998 edition of the American Medical Association's CPT (copyright 1997).

TOS – The *Customized Fee Analyzer* lists global fees for services in your specialty, or for all services when the all specialty Fee Analyzer is purchased, including those that can be split into technical (TC) and professional (26) components. The global fee and component splits are listed on separate lines with a G, TC, or 26 in the TOS field. If the service is 100 percent technical, the global service line shows the total amount, the technical component line shows the same total amount, and the professional component line shows zeroes. If the service is 100 percent professional, the global service and professional component lines show the same total amount, and the technical component line shows zeroes.

Sub – The Sub column indicates the status of the code with:

- Starred procedure, as defined in CPT
- C Change in procedure description from the previous edition
- N New code in CPT 1998
- D Deleted code in CPT 1998

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Description – The procedure code descriptions are 48-character abbreviations of the current CPT code descriptions.

MRVS – The fifth column contains the *Medicode Relative Value Study*. This copyright scale is a mix of historical charge-based and resource-based methodologies and has been in wide use throughout the industry since 1988. The study is updated in monthly meetings with coding, clinical, and statistical experts.

The relative value units (RVUs) for listed professional and technical component splits are the same as the global service RVU. Medicode creates its fee information for the component splits by changing the conversion factor, not by splitting the RVU by a percentage. You will find a table beginning on page 11 with Medicode's recommended PC/TC split percentages. This information allows you to determine how technical and professional amounts for your geographic area would be determined if the calculation was based on the PC/TC split percentage multiplied by the global fee.

Est Indem Allow – The *Analyzer's* sixth column (Estimated Indemnity Allowable) is a mathematic derivative of Medicode's provider charges databases. The proprietary formula used to derive this information was developed by Medicode in conjunction with insurance actuarial consultants. The resulting data is validated by comparing it to the allowable amounts used by some of our payer clients.

Area 50th – Percentiles are frequently misunderstood. A fee at the 50th percentile is not necessarily 50 percent of the highest charge. If your fee for a given service is at the 50th percentile, 50 percent of the submitted charges for that service are higher than your fee. If your fee is at the 75th percentile, 25 percent of the charges are higher than yours.

The 50th and the following 75th percentile columns represent the "highest frequency of charge range" for physician offices. Within this fee range you can expect to satisfy the payer industry's loose definition of usual, customary, and reasonable (UCR is often defined as "nondiscounted fee-for-service").

Area 75th – This column is the 75th percentile of our database for your geographic area.

Area 95th – This column is the 95th percentile of our database for your geographic area. This figure is included so that physicians can see as complete a picture as possible, but it is often inadvisable to bill at this level. In the current political atmosphere of cost containment, consistent high-level billing can be harmful to the financial well-being of your practice. As managed care networks become more prevalent, high-priced physicians may find themselves without an invitation to be involved with emerging alliances. Or, equally painful, find themselves losing patients who are increasingly unable or unwilling to tolerate high out-of-pocket expenses.

Comparing your charges to Medicode's data provides a "snapshot" of how your fee schedule stands in relation to other physicians in your area, and helps you see where you need to position your fees for successful negotiation of managed care contracts.

The relative value and fee data columns in *Customized Fee Analyzer* present a blend of two different methodologies. The RVS weighs medical procedures relative to one another on a scale linked to difficulty, work, risk, and the material costs of the procedure. The second ingredient can be characterized as simple statistical profiling of charges in the geographic areas.

While profiling alone has the benefit of reporting actual charges, the method presupposes coding accuracy, and the required data volume is very high. The accuracy of the analysis is strictly limited to the quality and quantity of the data set and does not address the question of whether the charges are reasonable. Since 80 percent of procedures billed are represented by less than 5 percent of codes, many statistical holes develop where the quantity of data is insufficient for confident analysis. Furthermore, studies show that up to 30 percent of all medical bills are coded inaccurately – a further compromise to good data analysis.

Medicode feels this method of combining the approaches merges the benefits of a relative value scale with the better features of actual charge data. This combination is further enhanced by our tremendous number of charges (now approximately 500 million), which allows us to array the data confidently by zip-code areas.

Please note that while thousands of payers and physician practices contribute to the data used in this product, no individual physician, clinic, or payer schedules appear in the data.

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CPT Code	TOS Sub	Description	MRVS	Avg Indem Allowable	Area 50th	Area 75th	Area 95th
64680		DESTRUCT CELIAC PLEXUS W/WO RAD	12.00	403-442	385	440	470
64702		NEUROPLASTY; DIGITAL 1/BOTH SAME	30.00	1008-1105	982	1099	1176
64704		NEUROPLASTY; NERV HAND/FT	38.00	1209-1326	1154	1319	1411
64708		NEUROPLSTY PERIPHRAL NERV; NOT SPECI	60.00	2015-2210	1923	2198	2352
64712		NEUROPLSTY PERIPHERAL NERV; SCIATIC	70.00	2351-2579	2244	2564	2745
64713		NEUROPLSTY PERIPHRAL; BRACHIAL PLEXS	74.00	2485-2726	2372	2711	2901
64714		NEUROPLSTY PERIPHRAL; LUMBAR PLEXUS	55.00	1847-2026	1783	2015	2156
64716		NEUROPLSTY/TRANSPOSIT; CRANIAL NERV	65.00	2183-2394	2084	2381	2549
64718		NEUROPLASTY; ULNAR NERV @ ELBOW	65.00	2183-2394	2084	2381	2549
64719		NEUROPLASTY; ULNAR NERV @ WRIST	43.50	1461-1602	1394	1593	1706
64721		NEUROPLASTY; MEDIAN @ CARPAL TUNNEL	46.00	1545-1694	1475	1685	1804
64722		DECOMP; UNSPECIFIED NERV (SPECIFY)	46.00	1545-1694	1475	1685	1804
64726		DECOMP; PLANTAR DIGITAL NERV	20.00	672-737	641	733	784
64727		INT NEUROLYSIS W/USE OR MICRO	0.00	0-0	0	0	0
64732		TRANSECT/AVULSION SUPRAORBITAL NERV	30.00	1008-1105	982	1099	1176
64734		TRANSECT/AVULSION INFRAORBITAL NERV	30.00	1008-1105	982	1099	1176
64736		TRANSECTION/AVULSION MENTAL NERV	38.00	1209-1326	1154	1319	1411
64738		TRANSECT INFERIOR ALVEOLAR NERV	44.00	1478-1621	1410	1612	1725
64740		TRANSECT/AVULSION LINGUAL NERV	55.00	1847-2026	1783	2015	2156
64742		TRANSECT FACIAL NERV DIFF/COMPLT	55.00	1847-2026	1783	2015	2156
64744		TRANSECT/AVULSION GREATR OCCIP NERV	35.00	1175-1289	1122	1282	1372

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CPT Code	TOS Sub	Description	MRVS	Est Indem Allowable	Area 50th	Area 75th	Area 95th
64702		NEUROPLASTY; DIGITAL 1/BOTH SAME	30.00	999-1186	966	1186	1342
64704		NEUROPLASTY; NERV HAND/FT	36.00	1199-1423	1159	1423	1610
64708		NEUROPLSTY PERIPHRAL NERV; NOT SPECI	60.00	1999-2372	1931	2372	2684
64712		NEUROPLSTY PERIPHERAL NERV; SCIATIC	70.00	2332-2767	2253	2767	3131
64713		NEUROPLSTY PERIPHRAL; BRACHIAL PLEXS	74.00	2465-2925	2382	2925	3310
64714		NEUROPLSTY PERIPHERAL; LUMBAR PLEXUS	55.00	1832-2174	1770	2174	2460
64716		NEUROPLSTY/TRANSPOSIT; CRANIAL NERV	65.00	2165-2569	2092	2569	2908
64718		NEUROPLASTY; ULNAR NERV @ ELBOW	65.00	2165-2569	2092	2569	2908
64719		NEUROPLASTY; ULNAR NERV @ WRIST	43.50	1449-1719	1400	1719	1946
64721		NEUROPLASTY; MEDIAN @ CARPAL TUNNEL	46.00	1532-1818	1481	1818	2058
64722		DECOMP; UNSPECIFIED NERV (SPECIFY)	46.00	1532-1818	1481	1818	2058
64726		DECOMP; PLANTAR DIGITAL NERV	20.00	666-791	644	791	895
64727		INT NEUROLYSIS W/USE OR MICRO	0.00	0-0	0	0	0
64732		TRANSECT/AVULSION SUPRAORBITAL NERV	30.00	999-1186	966	1186	1342
64734		TRANSECT/AVULSION INFRAORBITAL NERV	30.00	999-1186	966	1186	1342
64736		TRANSECTION/AVULSION MENTAL NERV	36.00	1199-1423	1159	1423	1610
64738		TRANSECT INFERIOR ALVEOLAR NERV	44.00	1466-1739	1416	1739	1968
64740		TRANSECT/AVULSION LINGUAL NERV	55.00	1832-2174	1770	2174	2460
64742		TRANSECT FACIAL NERV DIFF/COMPLT	55.00	1832-2174	1770	2174	2460
64744		TRANSECT/AVULSION GREATR OCCIP NERV	35.00	1166-1383	1127	1383	1566
64746		TRANSECT/AVULSION PHRENIC NERV	25.00	833-988	805	988	1118

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CPT Code	TOS	Sub	Description	MRVS	Avg Indem Allowable	Area 50th	Area 75th	Area 95th
99075			MED TESTIMONY	0.00	0-0	0	0	0
99078			PHYS EDUCAT SERV RENDERED IN GRP	0.00	0-0	0	0	0
99080			SPEC REPORT >INFO IN USUAL MED FORM	0.00	0-0	0	0	0
99082			UNUSUAL TRAVEL	0.00	0-0	0	0	0
99090			ANALYS INFORM DATA STORED-COMPUTERS	0.00	0-0	0	0	0
99201			OFFIC/OUTPT E&M NEW MINOR 10MIN	34.50	63-74	60	70	90
99202			OFFIC/OUTPT E&M NEW LOW-MOD 20MIN	43.00	79-92	75	88	112
99203			OFFIC/OUTPT E&M NEW MOD SEVER 30MIN	58.00	103-120	98	114	145
99204			OFFIC/OUTPT E&M NEW MOD-HI 45 MIN	80.00	147-171	140	163	208
99205			OFFIC/OUTPT E&M NEW MOD-HI 60 MIN	108.00	199-231	189	220	280
99211			OFFIC/OUTPT E&M ESTAB 5 MIN	19.00	39-45	36	43	49
99212			OFFIC/OUTPT E&M ESTAB MINOR 10MIN	27.00	59-64	51	62	70
99213			OFFIC/OUTPT E&M ESTAB LOW-MOD 15MIN	34.50	71-81	65	79	90
99214			OFFIC/OUTPT E&M ESTAB MOD-HI 25 MIN	50.00	103-118	94	114	130
99215			OFFIC/OUTPT E&M ESTAB MOD-HI 40 MIN	80.00	165-189	150	182	208
99217			OBSRV CARE D/C DA MGMT	60.00	94-118	84	111	164
99218			INIT OBSRV CARE-DA E&M LOW SEVERITY	75.00	118-147	105	139	205
99219			INIT OBSRV CARE-DA E&M MOD SEVERITY	102.00	160-201	143	189	278
99220			INIT OBSRV CARE-DA E&M HI SEVERITY	128.00	201-252	180	237	349
99221			INIT HOSP-DA E&M LOW SEVERITY 30MIN	83.50	131-164	117	155	228
99222			INIT HOSP-DA E&M MOD SEVERITY 50MIN	112.50	177-221	158	208	307

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CPT Code	TOS	Sub	Description	MRVS	Avg Indem Allowable	Area 50th	Area 75th	Area 95th
63011			LAMINECT W/EXPLOR 1-2 SEGMT; SACRAL	152.00	3987-4068	3939	4036	4637
63012			LAMINECT W/REMOV ABNL FACETS-LUMBAR	160.00	4176-4282	4146	4249	4881
63015			LAMINECT W/EXPLOR > 2 SEGMT; CERV	172.00	4489-4603	4457	4567	5247
63016			LAMINECT W/EXPLOR > 2 SEGMT; THORAC	180.00	4698-4817	4665	4780	5491
63017			LAMINECT W/EXPLOR > 2 SEGMT; LUMBAR	172.00	4489-4603	4457	4567	5247
63020			LAMINOT W/DECOMP; 1 INTERSPACE CERV	158.00	4123-4228	4094	4196	4820
63030			LAMINOT W/DECOMP; 1 INTERSPAC LUMB	153.00	3993-4094	3965	4063	4668
63035			LAMINOT; EA ADD INTERSPAC CERV/LUMB	50.00	1305-1338	1296	1328	1525
63040			LAMINOTOMY RE-EXPLOR; CERV	172.00	4489-4603	4457	4567	5247
63042			LAMINOTOMY RE-EXPLOR; LUMBAR	179.00	4672-4790	4639	4753	5461
63045			LAMINECTOMY 1 VERTEBRAL SEGMT; CERV	190.00	4959-5085	4924	5045	5796
63046			LAMINECTOMY 1 VERTEB SEGMT; THORACIC	185.00	4828-4951	4794	4912	5644
63047			LAMINECTOMY 1 VERTEB SEGMT; LUMBAR	185.00	4828-4951	4794	4912	5644
63048			LAMINECT 1 SEGMT; EA ADD CERV/LUMB	60.00	1566-1608	1555	1593	1830
63055			TRANSPEDICULAR SNGL SEGMT; THORACIC	205.00	5350-5486	5312	5444	6254
63056			TRANSPEDICULAR SNGL SEGMT; LUMBAR	188.00	4906-5031	4872	4992	5735
63057			TRANSPEDICULAR SNGL SEGMT; EA ADD	68.00	1775-1820	1782	1806	2074
63064			COSTOVERTEBRAL THORACIC; SNGL SEGMT	172.00	4489-4603	4457	4567	5247
63066			COSTOVERTEB THORACIC; EA ADD SEGMT	57.00	1488-1525	1477	1514	1739
63075			DISCECT ANT; CERV SNGL INTERSPACE	158.00	4123-4228	4094	4196	4820
63078			DISCECT ANT; CERV EA ADD INTERSPACE	53.00	1383-1418	1373	1407	1617

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CPT Code	TOS	Sub	Description	MRVS	Avg Indem Allowable	Area 50th	Area 75th	Area 95th
72072	28		RAD EXAM SPINE; THORAC W/SWIM VIEW	74.00	48-55	42	53	64
72074	G		RAD EXAM SPINE; THORACIC COMPLT	85.00	131-159	121	151	185
72074	TC		RAD EXAM SPINE; THORACIC COMPLT	85.00	79-96	73	91	111
72074	28		RAD EXAM SPINE; THORACIC COMPLT	85.00	52-63	48	60	74
72080	G		RAD EXAM SPINE; THORACOLUM AP & LAT	72.00	111-134	103	128	157
72080	TC		RAD EXAM SPINE; THORACOLUM AP & LAT	72.00	67-80	62	77	94
72080	28		RAD EXAM SPINE; THORACOLUM AP & LAT	72.00	44-54	41	51	63
72090	G		RAD EXAM SPINE; SCOLIOSIS STUDY	85.00	131-159	121	151	185
72090	TC		RAD EXAM SPINE; SCOLIOSIS STUDY	85.00	79-96	73	91	111
72090	28		RAD EXAM SPINE; SCOLIOSIS STUDY	85.00	52-63	48	60	74
72100	G		RAD EXAM SPINE LUMBOSACR; AP & LAT	85.00	100-121	93	116	142
72100	TC		RAD EXAM SPINE LUMBOSACR; AP & LAT	65.00	60-72	56	70	85
72100	28		RAD EXAM SPINE LUMBOSACR; AP & LAT	85.00	40-49	37	46	57
72110	G		RAD EXAM SPINE LUMBOSACRAL; W/OBLIQ	95.00	146-177	135	169	207
72110	TC		RAD EXAM SPINE LUMBOSACRAL; W/OBLIQ	95.00	87-106	81	101	124
72110	28		RAD EXAM SPINE LUMBOSACRAL; W/OBLIQ	95.00	59-71	54	68	83
72114	G		RAD EXAM SPINE LUMBOSACRAL; W/BEND	120.00	185-224	171	213	261
72114	TC		RAD EXAM SPINE LUMBOSACRAL; W/BEND	120.00	111-134	103	128	156
72114	28		RAD EXAM SPINE LUMBOSACRAL; W/BEND	120.00	74-90	68	85	105
72120	G		RAD EXAM SPINE LUMBOSACRAL MINI 4	93.00	143-174	133	165	203
72120	TC		RAD EXAM SPINE LUMBOSACRAL MINI 4	93.00	86-105	80	99	122

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CPT Code	TOS	Sub	Description	MRVS	Est Indem Allowable	Area 50th	Area 75th	Area 95th
99201			OFFIC/OUTPT E&M NEW MINOR 10MIN	34.50	69-78	66	76	93
99202			OFFIC/OUTPT E&M NEW LOW-MOD 20MIN	43.00	85-98	82	94	116
99203			OFFIC/OUTPT E&M NEW MOD SEVER 30MIN	56.00	111-127	107	123	151
99204			OFFIC/OUTPT E&M NEW MOD-HI 45 MIN	80.00	159-182	153	175	216
99205			OFFIC/OUTPT E&M NEW MOD-HI 60 MIN	108.00	215-245	206	236	292
99211			OFFIC/OUTPT E&M ESTAB 5 MIN	19.00	43-48	40	46	51
99212			OFFIC/OUTPT E&M ESTAB MINOR 10MIN	27.00	61-68	57	66	73
99213			OFFIC/OUTPT E&M ESTAB LOW-MOD 15MIN	34.50	78-86	73	84	93
99214			OFFIC/OUTPT E&M ESTAB MOD-HI 25 MIN	50.00	113-125	105	122	136
99215			OFFIC/OUTPT E&M ESTAB MOD-HI 40 MIN	80.00	181-200	168	195	217
99217			OBSRV CARE D/C DA MGMT	60.00	124-143	114	137	190
99218			INIT OBSRV CARE-DA E&M LOW SEVERITY	75.00	155-179	142	172	237
99219			INIT OBSRV CARE-DA E&M MOD SEVERITY	102.00	210-243	193	234	322
99220			INIT OBSRV CARE-DA E&M HI SEVERITY	128.00	284-305	242	293	404
99221			INIT HOSP-DA E&M LOW SEVERITY 30MIN	83.50	172-199	158	191	264
99222			INIT HOSP-DA E&M MOD SEVERITY 50MIN	112.50	232-268	213	258	356
99223			INIT HOSP-DA E&M HI SEVERITY 70 MIN	138.00	285-329	261	316	436
99231			SUBSQT HOSP-DA E&M STABLE 15 MIN	44.00	91-105	83	101	139
99232			SUBSQT HOSP-DA E&M MINR COMPL 25MIN	60.00	124-143	114	137	190
99233			SUBSQT HOSP-DA E&M SIG COMPL 35 MIN	88.50	183-211	168	203	280
99234			OBSRV/INPT HOSP CARE E&M LOW SEVER	82.50	170-197	156	189	261

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CPT Code	TOS Sub	Description	MRVS	Est Indem Allowable	Area 50th	Area 75th	Area 95th
63012		LAMINECT W/REMOV ABNL FACETS-LUMBAR	160.00	4628-4976	4446	4879	5536
63015		LAMINECT W/EXPLOR > 2 SEGMENT: CERV	172.00	4975-5350	4779	5245	5951
63016		LAMINECT W/EXPLOR > 2 SEGMENT: THORAC	180.00	5206-5598	5001	5489	6228
63017		LAMINECT W/EXPLOR > 2 SEGMENT: LUMBAR	172.00	4975-5350	4779	5245	5951
63020		LAMINOT W/DECOMP: 1 INTERSPACE CERV	158.00	4570-4914	4390	4818	5467
63030		LAMINOT W/DECOMP: 1 INTERSPAC LUMB	153.00	4425-4759	4251	4665	5294
63035		LAMINOT: EA ADD INTERSPAC CERV/LUMB	50.00	1446-1555	1389	1525	1730
63040		LAMINOTOMY RE-EXPLOR: CERV	172.00	4975-5350	4779	5245	5951
63042		LAMINOTOMY RE-EXPLOR: LUMBAR	179.00	5177-5567	4974	5458	6194
63045		LAMINECT 1 VERT SEGMENT-UNIBIL: CERV	190.00	5496-5909	5279	5794	6574
63046		LAMINECT 1 VERT SEGMENT-UNIBIL: THOR	185.00	5351-5754	5140	5641	6401
63047		LAMINECT 1 VERT SEGMENT-UNIBIL: LUMB	185.00	5351-5754	5140	5641	6401
63048		LAMINECT 1 SEGMENT-UNIBIL: EA ADD'L	60.00	1735-1866	1667	1830	2076
63055		TRANSPEDICULAR SNGL SEGMENT: THORACIC	205.00	5929-6376	5696	6251	7093
63056		TRANSPEDICULAR SNGL SEGMENT: LUMBAR	188.00	5438-5847	5224	5733	6505
63057		TRANSPEDICULAR SNGL SEGMENT: EA ADD	68.00	1967-2115	1889	2074	2353
63064		COSTOVERTEBRAL THORACIC: SNGL SEGMENT	172.00	4975-5350	4779	5245	5951
63066		COSTOVERTEBRAL THORACIC: EA ADD SEGMENT	57.00	1649-1773	1584	1738	1972
63075		DISKECT ANT: CERV SNGL INTERSPACE	158.00	4570-4914	4390	4818	5467
63076		DISKECT ANT: CERV EA ADD INTERSPACE	53.00	1533-1648	1473	1616	1834
63077		DISKECT ANT: THORACIC 1 INTERSPACE	150.00	4339-4665	4168	4574	5190

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CPT Code	TOS	Sub	Description	MRVS	Est Indem Allowable	Area 50th	Area 75th	Area 95th
22315			CLO TX VERT FX/DISLOC W/CAST-MANIP	40.00	1193-1331	1188	1209	1904
22325			OPEN TX VERT FX/DISLOC-POST-1; LUMB	115.00	3429-3826	3416	3475	5474
22326			OPEN TX VERT FX/DISLOC-POST-1; CERV	125.00	3727-4159	3713	3777	5950
22327			OPEN TX VERT FX/DISLOC-POST-1; THOR	120.00	3578-3993	3564	3626	5712
22328			OP TX VERT FX/DISLOC-POST; EA ADD	36.00	1073-1198	1069	1088	1714
22505			MANIP SPINE REQUIR ANES ANY REGION	11.50	343-383	342	347	547
22548			ARTHRODESIS-C1 C2-W/WO EXC ODDONTOID	147.50	4534-4818	4491	4792	6460
22554			ARTHRODESIS W/MINI DISSECT; C3-C7	142.50	4381-4655	4339	4630	6241
22556			ARTHRODESIS W/MINI DISSECT; THOR	157.50	4842-5145	4796	5117	6898
22558			ARTHRODESIS W/MINI DISSECT; LUMB	142.50	4381-4655	4339	4630	6241
22585			ARTHRODESIS W/MINI DISSECT; EA ADD	42.75	1314-1396	1302	1389	1872
22590			ARTHRODESIS-POST TECH. CRANIOCERV	162.50	4995-5308	4948	5280	7117
22595			ARTHRODESIS-POST TECH. ATLAS-AXIS	165.50	5088-5406	5039	5377	7249
22600			ARTHRODESIS-POST/POSTLAT-1; C3-C7	142.50	4381-4655	4339	4630	6241
22610			ARTHRODESIS-POST/POSTLAT-1; THOR	132.50	4073-4328	4034	4305	5803
22612			ARTHRODESIS-POST/POSTLAT-1; LUMB	129.00	3966-4214	3928	4191	5650
22614			ARTHRODESIS-POST/LAT; EA ADD SEGMENT	43.00	1322-1405	1309	1397	1883
22630			ARTHRODESIS-POST INTERBODY-1; LUMB	125.00	3843-4083	3806	4061	5475
22632			ARTHRODESIS-POST INTERBODY; EA ADD	41.50	1276-1356	1264	1348	1818
22800			ARTHRODESIS-POST; 6/LESS VERT SEGMENT	172.50	5303-5635	5252	5605	7555
22802			ARTHRODESIS-POST; 7-12 VERTEB SEGMENT	207.00	6363-6762	6303	6726	9066

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CPT Code	TOS	Sub	Description	MRVS	Est Indem Allowable	Area 50th	Area 75th	Area 95th
63012			LAMINECT W/REMOV ABNL FACETS-LUMBAR	160.00	4628-4976	4446	4879	5536
63015			LAMINECT W/EXPLOR > 2 SEGMENT; CERV	172.00	4975-5350	4779	5245	5951
63016			LAMINECT W/EXPLOR > 2 SEGMENT; THORAC	180.00	5206-5598	5001	5489	6228
63017			LAMINECT W/EXPLOR > 2 SEGMENT; LUMBAR	172.00	4975-5350	4779	5245	5951
63020			LAMINOT W/DECOMP; 1 INTERSPACE CERV	158.00	4570-4914	4390	4818	5467
63030			LAMINOT W/DECOMP; 1 INTERSPACE LUMB	153.00	4425-4759	4251	4665	5294
63035			LAMINOT; EA ADD INTERSPACE CERV/LUMB	50.00	1446-1555	1389	1525	1730
63040			LAMINOTOMY RE-EXPLOR; CERV	172.00	4975-5350	4779	5245	5951
63042			LAMINOTOMY RE-EXPLOR; LUMBAR	179.00	5177-5567	4974	5458	6194
63045			LAMINECT 1 VERT SEGMENT-UNIBIL; CERV	190.00	5496-5909	5279	5794	6574
63046			LAMINECT 1 VERT SEGMENT-UNIBIL; THOR	185.00	5351-5754	5140	5641	6401
63047			LAMINECT 1 VERT SEGMENT-UNIBIL; LUMB	185.00	5351-5754	5140	5641	6401
63048			LAMINECT 1 SEGMENT-UNIBIL; EA ADD'L	60.00	1735-1866	1667	1830	2076
63055			TRANSPEDICULAR SNGL SEGMENT; THORACIC	205.00	5929-6376	5696	6251	7093
63056			TRANSPEDICULAR SNGL SEGMENT; LUMBAR	188.00	5438-5847	5224	5733	6505
63057			TRANSPEDICULAR SNGL SEGMENT; EA ADD	68.00	1967-2115	1889	2074	2353
63064			COSTOVERTEBRAL THORACIC; SNGL SEGMENT	172.00	4975-5350	4779	5245	5951
63066			COSTOVERTEB THORACIC; EA ADD SEGMENT	57.00	1649-1773	1584	1738	1972
63075			DISKECT ANT; CERV SNGL INTERSPACE	158.00	4570-4914	4390	4818	5467
63076			DISKECT ANT; CERV EA ADD INTERSPACE	53.00	1533-1648	1473	1616	1834
63077			DISKECT ANT; THORACIC 1 INTERSPACE	150.00	4339-4665	4168	4574	5190

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CPT Code	TOS Sub	Description	MRVS	Est Indem Allowable	Area 50th	Area 75th	Area 95th
20900		BONE GFT ANY DONOR AREA: MINOR/SM	19.00	628-733	605	700	873
20902		BONE GFT ANY DONOR AREA: MAJOR/LG	38.00	1255-1465	1210	1401	1745
20910		CARTILAGE GFT: COSTOCHONDRAL	28.00	925-1080	892	1032	1286
20912		CARTILAGE GFT: NASAL SEPTUM	33.00	1090-1273	1051	1217	1516
20920		FASCIA LATA GFT: BY STRIPPER	22.00	727-848	701	811	1010
20922		FASCIA LATA GFT: INCS & AREA EXPOSU	30.00	991-1157	956	1106	1378
20924		TENDON GFT FROM A DISTANCE	21.00	694-810	669	774	965
20926		TISS GFT OTHER	20.00	661-771	637	737	919
20930		ALLOGFT SPINE SURG ONLY: MORSELIZED	11.50	380-443	366	424	528
20931		ALLOGFT SPINE SURG ONLY: STRUCTURAL	14.00	462-540	446	516	643
20936		AUTOGFT SPIN SURG: LOCAL-SAME INCIS	17.50	578-675	557	645	804
20937		AUTOGFT SPINE SURG ONLY: MORSELIZED	30.50	1007-1176	972	1124	1401
20938		AUTOGFT SPIN SURG: STRUC/BI-TRICORT	38.00	1255-1465	1210	1401	1745
20950		MONITOR PRESS-DETECT MUSCL COMPARTM	7.00	231-270	223	258	322
20955		BONE GFT W/MICROVASC ANASTOM: FIBUL	112.50	3716-4339	3584	4147	5167
20956		BONE GFT W/MICROVASC ANASTOM: ILIAC	112.50	3716-4339	3584	4147	5167
20957		BONE GFT W/MICROVAS ANAS: METATARS	112.50	3716-4339	3584	4147	5167
20962		BONE GFT W/MICROVASC ANASTOM: OTHER	112.50	3716-4339	3584	4147	5167
20969		FREE OSTEOCUT FLAP: NOT ILIAC CREST	150.00	4954-5785	4778	5530	6890
20970		FREE OSTEOCUT FLAP: ILIAC CREST	150.00	4954-5785	4778	5530	6890
20972		FREE OSTEOCUT FLAP: METATARS	150.00	4954-5785	4778	5530	6890

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CPT Code	TOS Sub Description	MBVS	Avg Indem Allowable	Area 50th	Area 75th	Area 95th
63040	LAMINOTOMY RE-EXPLOR: CERV	172.00	4309-4796	3942	4621	5496
63042	LAMINOTOMY RE-EXPLOR: LUMBAR	179.00	4484-4992	4103	4810	5720
63045	LAMINECTOMY 1 VERTEBRAL SEGMENT: CERV	190.00	4760-5298	4355	5105	6071
63046	LAMINECTOMY 1 VERTEB SEGMENT: THORACIC	185.00	4634-5159	4240	4971	5911
63047	LAMINECTOMY 1 VERTEB SEGMENT: LUMBAR	185.00	4634-5159	4240	4971	5911
63048	LAMINECT 1 SEGMENT: EA ADD CERV/LUMB	60.00	1503-1673	1375	1612	1917
63055	TRANSPEDICULAR SNGL SEGMENT: THORACIC	205.00	5135-5717	4698	5508	6550
63056	TRANSPEDICULAR SNGL SEGMENT: LUMBAR	188.00	4710-5243	4309	5051	6007
63057	TRANSPEDICULAR SNGL SEGMENT: EA ADD	68.00	1703-1896	1558	1827	2173
63064	COSTOVERTEBRAL THORACIC: SNGL SEGMENT	172.00	4309-4796	3942	4621	5496
63066	COSTOVERTEB THORACIC: EA ADD SEGMENT	57.00	1428-1590	1306	1532	1821
63075	DISSECT ANT: CERV SNGL INTERSPACE	158.00	3958-4406	3621	4245	5049
63076	DISSECT ANT: CERV EA ADD INTERSPACE	53.00	1328-1478	1215	1424	1694
63077	DISSECT ANT: THORACIC 1 INTERSPACE	150.00	3758-4183	3418	4030	4793
63078	DISSECT: THORACIC EA ADD INTERSPACE	50.00	1253-1394	1146	1343	1598
63081	VERTEBRAL CORPECTOMY: CERV 1 SEGMENT	190.00	4760-5298	4355	5105	6071
63082	VERTEBRAL CORPECT: CERV EA AD SEGMENT	63.00	1578-1757	1444	1693	2013
63085	VERTEBRAL CORPECT: THORACIC 1 SEGMENT	190.00	4760-5298	4355	5105	6071
63086	VERTEBRAL CORPECT: THORAC EA AD SEG	63.00	1578-1757	1444	1693	2013
63087	VERTEB CORPECT LOW THORACIC/LUMB: 1	182.00	4559-5075	4171	4890	5815
63088	VERTEB CORPECT THORAC/LUMB: EA ADD	61.00	1520-1701	1398	1639	1949

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CPT Code	IOS Sub	Description	HRVS	Avg Indem Allowable	Area 50th	Area 75th	Area 95th
22310	C	CLO TX VERT BODY FX WO MANIP-W/CAST	27.50	713-910	693	774	1052
22315	C	CLO TX VERT FX/DISLOC W/CAST-MANIP	40.00	1037-1324	1008	1125	1531
22325	C	OPEN TX VERT FX/DISLOC-POST-1: LUMB	115.00	2981-3808	2898	3235	4401
22326	C	OPEN TX VERT FX/DISLOC-POST-1: CERV	125.00	3240-4139	3150	3517	4783
22327	C	OPEN TX VERT FX/DISLOC-POST-1: THOR	120.00	3111-3973	3024	3376	4592
22328	N	OP TX VERT FX/DISLOC-POST: EA ADD	36.00	933-1192	907	1013	1378
22505		MANIP SPINE REQUIR ANES ANY REGION	11.50	298-381	290	324	440
22548	C	ARTHRODESIS-C1 C2-W/O EXC ODONTOID	152.50	3953-4897	3702	4290	5675
22554	C	ARTHRODESIS W/MINI DISSECT: C3-C7	147.50	3823-4736	3580	4150	5489
22556	C	ARTHRODESIS W/MINI DISSECT: THOR	162.50	4212-5218	3945	4572	6047
22558	C	ARTHRODESIS W/MINI DISSECT: LUMB	147.50	3823-4736	3580	4150	5489
22585	C	ARTHRODESIS W/MINI DISSECT: EA ADD	43.00	1115-1381	1044	1210	1600
22590	C	ARTHRODESIS-POST TECH. CRANIOCERV	167.50	4342-5378	4066	4712	6233
22595	C	ARTHRODESIS-POST TECH. ATLAS-AXIS	165.50	4290-5314	4017	4656	6158
22600	C	ARTHRODESIS-POST/POSTLAT-1: C3-C7	142.50	3694-4576	3459	4009	5303
22610	C	ARTHRODESIS-POST/POSTLAT-1: THOR	132.50	3435-4255	3216	3728	4930
22612	C	ARTHRODESIS-POST/POSTLAT-1: LUMB	129.00	3344-4142	3131	3629	4880
22614	N	ARTHRODESIS-POST/LAT: EA ADD SEGNT	43.00	1115-1381	1044	1210	1600
22625	D	ARTHRODESIS LAT W/GFT-FIXA LUMBAR	155.00	4018-4977	3762	4361	5768
22630	C	ARTHRODESIS-POST INTERBODY-1: LUMB	125.00	3240-4014	3034	3517	4651
22632	N	ARTHRODESIS-POST INTERBODY: EA ADD	41.50	1076-1333	1007	1168	1544

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CPT Code	TOS Sub Description	MRVS	Avg Indem Allowable	Area 50th	Area 75th	Area 95th
20938	AUTOGFT SPIN SURG: STRUC/BI-TRICORT	38.00	990-1111	932	1076	1294
20950	MONITOR PRESS-DETECT MUSCL COMPARTM	7.00	182-205	172	198	238
20955	BONE GFT W/MICROVASC ANASTOM: FIBUL	150.00	3908-4384	3680	4248	5106
20960	BONE GFT W/MICROVASC ANASTOM: RIB	150.00	3908-4384	3680	4248	5106
20962	BONE GFT W/MICROVASC ANASTOM: OTHER	175.00	4559-5115	4294	4957	5958
20969	FREE OSTEOCUT FLAP: NOT ILIAC CREST	200.00	5210-5845	4907	5665	6809
20970	FREE OSTEOCUT FLAP: ILIAC CREST	200.00	5210-5845	4907	5665	6809
20971	FREE OSTEOCUT FLAP: RIB	200.00	5210-5845	4907	5665	6809
20972	FREE OSTEOCUT FLAP: METATARS	200.00	5210-5845	4907	5665	6809
20973	FREE OSTEOCUT FLAP: CRT TOE	213.00	5549-6225	5226	6033	7251
20974	ELEC STIM-AID BONE HEAL: NONINVASIV	25.00	651-731	613	708	851
20975	ELEC STIM-AID BONE HEAL: INVASIVE	40.00	1042-1169	981	1133	1362
20999	UNLISTED PROC NS SYST GEN	0.00	0-0	0	0	0
21010	ARTHROTOMY TEMPOROMANDIBULAR JT	105.50	2832-3036	2331	3036	4117
21015	RAD RESEC TUMOR SOFT TISS FACE/SCLP	0.00	0-0	0	0	0
21025	EXC BONE: MANDIB	70.00	1879-2015	1547	2015	2732
21026	EXC BONE: FACIAL BONE	75.00	2013-2159	1657	2159	2927
21029	REMOV-CONTOURING BEN TUMOR FACE BONE	84.00	2255-2418	1856	2418	3278
21030	EXC BEN TUMOR FACE BONE NOT MANDIB	47.00	1261-1353	1030	1353	1834
21031	EXC TORUS MANDIBULARIS	17.55	471-505	388	505	685
21032	EXC MAXIL TORUS PALATINUS	25.00	671-720	552	720	976

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CPT Code	TOS	Sub	Description	MRVS	Avg Indem Allowable	Area 50th	Area 75th	Area 95th
26010			DRAINAGE FINGER ABSCESS; SIMPL	4.00	113-130	111	125	166
26011			DRAINAGE FINGER ABSCESS; COMPLIC	15.00	425-486	416	467	621
26020			DRAIN TENDON SHEATH 1 DIGIT/PALM	30.00	851-972	833	934	1242
26025			DRAIN PALM BURSA; SNGL ULNAR/RADIAL	30.00	851-972	833	934	1242
26030			DRAIN PALMAR BURSA; MX/COMPLIC	70.00	1985-2268	1943	2180	2897
26034			INCS DEEP W/OPEN BONE CORTEX HAND	32.00	908-1037	888	998	1325
26035			DECOMP FINGERS &/OR HAND INJ INJURY	70.00	1985-2268	1943	2180	2897
26037			DECOMP FASCIOTOMY HAND	30.00	851-972	833	934	1242
26040	C		FASCIOTOMY PALMAR; PERCUT	21.00	598-680	583	654	869
26045			FASCIOTOMY PALMAR; OPEN PART	30.00	851-972	833	934	1242
26055			TENDON SHEATH INCS	26.00	737-842	722	810	1076
26060	C		TENOTOMY PERCUT SNGL EA DIGIT	13.00	389-421	381	406	538
26070	C		ARTHROT W/EXPLOR; CARPOMETACARP JT	30.00	851-972	833	934	1242
26075	C		ARTHROT W/EXPLOR/DRAIN; MCP JT	30.00	851-972	833	934	1242
26080	C		ARTHROT W/EXPLOR/DRAIN; IP JT EA	24.00	681-778	688	747	993
26100			ARTHROTOMY W/SYNOVIAL BX; CMC JT	30.00	851-972	833	934	1242
26105			ARTHROTOMY W/SYNOVIAL BX; MCP JT	25.00	709-810	694	779	1035
26110			ARTHROTOMY W/SYNOVIAL BX; IP JT EA	21.00	598-680	583	654	869
26115			EXC TUMOR HAND/FINGER; SUBQ	20.00	567-646	555	623	828
26116			EXC TUMOR HAND/FINGER; DEEP/IM	32.00	908-1037	888	998	1325
26117			RAD RESECT TUMOR TISS HAND/FINGER	105.00	2978-3402	2914	3270	4346

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CPT Code	TOS	Sub	Description	MRVS	Avg Indem Allowable	Area 50th	Area 75th	Area 95th
23221			RAD RESEC TUMR PROX HUME; W/AUTOGFT	120.00	3488-3685	3400	3882	4468
23222			RAD RESECT TUM PROX HUMER; W/PROSTH	120.00	3488-3685	3400	3882	4468
23330			REMOV FB SHOULDER; SUBQ	5.00	174-184	170	183	223
23331			REMOV FB SHOULDER; DEEP	30.00	872-921	850	916	1117
23332			REMOV FB SHOULDR; COMPLIC-TOT SHOU	110.00	3198-3378	3117	3357	4098
23350			INJ PROC SHOULDER ARTHROGRAPHY	5.00	145-154	142	153	188
23395			MUSCL TRANSF-SHOULDER/UP ARM; SNGL	100.00	2907-3071	2834	3052	3724
23397			MUSCL TRANSF-SHOULDER/UP ARM; MX	0.00	0-0	0	0	0
23400			SCAPULOPEXY	100.00	2907-3071	2834	3052	3724
23405			TENOMYOTOMY SHOULDER AREA; SNGL	50.00	1454-1535	1417	1528	1882
23406			TENOMYOTOMY SHOULDER; MX SAME INCS	65.00	1890-1996	1842	1984	2420
23410			REPR RUPT MUSCULOTENDIN CUFF; ACUTE	75.50	2195-2318	2138	2304	2811
23412			REPR RUPT MUSCULOTENDIN CUFF; CHRON	90.00	2616-2764	2550	2747	3351
23415			CORACOACROM LIG REL W/WO ACROMIOPLA	52.00	1512-1597	1474	1587	1938
23420			REPR COMPLY SHOULDER CUFF AVUL CHRO	115.00	3343-3531	3258	3510	4282
23430			TENODESIS LONG TENDON BICEPS	68.00	1977-2088	1927	2075	2532
23440			RESECT/TRANSPL LONG TENDON BICEPS	60.00	1744-1842	1700	1831	2234
23450			CAPSULORRHAPHY ANT; PUTTI-PLATT TYP	94.00	2733-2887	2684	2888	3500
23455			CAPSULORRHAPHY ANT; BANKART TYPE	105.00	3052-3224	2975	3204	3910
23480			CAPSULORRHAPHY ANT; W/BONE BLOCK	100.00	2907-3071	2834	3052	3724
23482			CAPSULORRHAPHY ANT; W/CORACOID TRNS	100.00	2907-3071	2834	3052	3724

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CPT Code	TOS	Sub	Description	MRVS	Avg Indem Allowable	Area 50th	Area 75th	Area 95th
25545			OPEN TX ULNAR SHAFT FX W/WO FIXA	55.50	1484-1605	1389	1570	1746
25580			CLO TX RAD & ULNA SHAFT FX; WO MANI	20.00	527-579	501	586	629
25585			CLO TX RAD & ULNA SHAFT FX; W/MANIP	38.00	1002-1099	951	1075	1186
25574			OPEN TX RAD & ULNA FX; RADIUS/ULNA	74.00	1951-2141	1882	2083	2326
25575			OPEN TX RAD & ULNA FX; RAD & ULNA	81.00	2136-2343	2027	2291	2549
25600			CLO TX DIST RAD FX; WO MANIP	17.25	455-499	432	488	543
25605			CLO TX DIST RAD FX; W/MANIP	26.50	689-767	683	750	834
25611			PERCUT FIX DISTAL RAD FX W/MANIP	45.00	1187-1302	1126	1273	1416
25620			OPEN TX DIST RAD FX W/WO FIXA	54.00	1424-1562	1352	1527	1699
25622			CLO TX CARPAL SCAPHOID FX; WO MANIP	18.50	488-535	483	523	582
25624			CLO TX CARPAL SCAPHOID FX; W/MANIP	24.00	633-694	601	679	755
25628			OPEN TX CARPAL SCAPHOID FX W/WO FIX	52.00	1371-1504	1301	1471	1636
25630			CLO TX CARPAL BONE FX; WO MANIP EA	15.25	402-441	382	431	480
25635			CLO TX CARPAL BONE FX; W/MANIP EA	25.00	659-723	626	707	787
25645			OPEN TX CARPAL BONE FX EA BONE	37.50	989-1085	939	1061	1180
25650			CLO TX ULNAR STYLOID FX	22.00	580-636	551	622	682
25660			CLO TX RADIOCARPAL DISLOC W/MANIP	25.00	659-723	626	707	787
25670			OPEN TX RADIOCARPAL DISLOC 1/MORE	50.00	1319-1446	1251	1414	1573
25675			CLO TX RADIOULNAR DISLOC W/MANIP	20.00	527-579	501	586	629
25676			OPEN TX RADIOULN DISLOC ACUTE/CHRON	40.00	1055-1157	1001	1131	1259
25680			CLO TX TRANS-SCAPHOPERILUNAR W/MANI	35.50	936-1027	888	1004	1117

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CPT Code	TOS	Sub	Description	MRVS	Avg Indem Allowable	Area 50th	Area 75th	Area 95th
73060	26		RAD EXAM; HUMERUS MINI 2 VIEWS	58.00	38-44	35	42	50
73070	G		RAD EXAM ELBOW; AP & LAT VIEWS	52.00	65-96	79	94	112
73070	TC		RAD EXAM ELBOW; AP & LAT VIEWS	52.00	51-59	47	56	67
73070	26		RAD EXAM ELBOW; AP & LAT VIEWS	52.00	34-39	32	38	45
73080	G		RAD EXAM ELBOW; COMPLT MINI 3 VIEWS	58.00	95-110	88	105	125
73080	TC		RAD EXAM ELBOW; COMPLT MINI 3 VIEWS	58.00	57-66	53	63	75
73080	26		RAD EXAM ELBOW; COMPLT MINI 3 VIEWS	58.00	38-44	35	42	50
73085	G		RAD EXAM ELBOW ARTHROGRAPHY-S & I	184.00	300-348	279	332	397
73085	TC		RAD EXAM ELBOW ARTHROGRAPHY-S & I	184.00	195-226	181	216	258
73085	26		RAD EXAM ELBOW ARTHROGRAPHY-S & I	184.00	105-122	98	116	139
73090	G		RAD EXAM; FOREARM AP & LAT VIEWS	50.00	82-95	76	90	106
73090	TC		RAD EXAM; FOREARM AP & LAT VIEWS	50.00	49-57	46	54	65
73090	26		RAD EXAM; FOREARM AP & LAT VIEWS	50.00	33-38	30	36	43
73092	G		RAD EXAM; UPPER EXTREM INFANT MIN 2	53.00	87-100	80	96	114
73092	TC		RAD EXAM; UPPER EXTREM INFANT MIN 2	53.00	52-60	48	56	68
73092	26		RAD EXAM; UPPER EXTREM INFANT MIN 2	53.00	35-40	32	38	46
73100	G		RAD EXAM WRIST; AP & LAT VIEWS	46.00	75-87	70	83	99
73100	TC		RAD EXAM WRIST; AP & LAT VIEWS	46.00	45-52	42	50	59
73100	26		RAD EXAM WRIST; AP & LAT VIEWS	46.00	30-35	28	33	40
73110	G		RAD EXAM WRIST; COMPLT MINI 3 VIEWS	52.00	85-96	79	94	112
73110	TC		RAD EXAM WRIST; COMPLT MINI 3 VIEWS	52.00	51-59	47	56	67

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CPT Code	TOS	Sub Description	HRVS	Avg Indem Allowable	Area 50th	Area 75th	Area 95th
62298	*	INJ SUBSTANCE EPIDURAL (SEP PRO)	19.00	452-508	436	484	713
62350	N	IMPLNT/REVIS EPIDUR CATH: WO LAMNECT	110.00	2616-2939	2524	2804	4129
62351	N	IMPLNT/REVIS EPIDUR CATH: W/LAMNECT	130.00	3092-3474	2982	3314	4879
62355	N	REMOV PREV IMPLNT INTNEC/EPDUR CATH	50.00	1189-1336	1147	1275	1877
62360	N	IMPLNT/REPLAC DEVIC-EPIDUR: RESVOIR	52.00	1237-1389	1193	1326	1952
62361	N	IMPLNT/REPLC DEVIC-EPIDUR: NONPROGM	52.00	1237-1389	1193	1326	1952
62362	N	IMPLNT/REPLAC DEVIC-EPIDUR: PROGMBL	55.00	1308-1470	1262	1402	2064
62365	N	REMOV PREV IMPLNT SUBQ RESVOIR/PUMP	33.00	785-882	757	841	1239
62367	N	ELEC ANALY PROGRM PUMP: WO REPROGRM	0.00	0-0	0	0	0
62368	N	ELEC ANALYS PROGRM PUMP: W/REPROGRM	0.00	0-0	0	0	0
63001		LAMINECT W/EXPLOR 1-2 VERTES: CERV	140.00	3507-3904	3209	3762	4473
63003		LAMINECT W/EXPLOR 1-2 VERTES: THORA	160.00	4008-4462	3667	4299	5112
63005		LAMINECT W/EXPLOR: LUMBAR EX SPONDY	135.00	3382-3765	3094	3627	4314
63011		LAMINECT W/EXPLOR 1-2 SEGNT: SACRAL	152.00	3808-4239	3484	4084	4857
63012		LAMINECT W/REMOV ASNL FACETS-LUMBAR	160.00	4008-4462	3667	4299	5112
63015		LAMINECT W/EXPLOR > 2 SEGNT: CERV	172.00	4309-4796	3942	4621	5496
63016		LAMINECT W/EXPLOR > 2 SEGNT: THORAC	180.00	4509-5019	4125	4836	5752
63017		LAMINECT W/EXPLOR > 2 SEGNT: LUMBAR	172.00	4309-4796	3942	4621	5496
63020		LAMINOT W/DECOMP: 1 INTERSPACE CERV	158.00	3958-4406	3621	4245	5049
63030		LAMINOT W/DECOMP: 1 INTERSPAC LUMB	153.00	3833-4267	3507	4111	4889
63035		LAMINOT: EA ADD INTERSPAC CERV/LUMB	50.00	1253-1394	1146	1343	1598

U1295-D1095

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E-23

August 5, 1996

William #132852

Mr. [redacted] has had back pain, left hip pain, and pain in the right thigh for about 1 to 2 months. It has gotten worse over the last month and seems to have radiated somewhat from the below knee ^{radiating to} ~~impacted~~ to the left hip area. Initially it started with just back pain and then pain in the right leg which got better, then pain in the left sacroiliac and hip area started. He has a history of previous mild backaches in the past which have resolved spontaneously. No history of sciatica and no history of back surgery. He denies any bowel or bladder problems and denies any muscle weakness. He says he is very stiff in the morning. He gets a little better as the day goes on.

He was seen in the emergency room in Fort Smith, Arkansas and was given a muscle relaxant. The injury occurred the weekend of April 13, 1996.

On exam the patient walks around the room well. Heel and toe walking are normal. Straight leg raising is positive at about 30° with left hip and posterior thigh pain. Right leg straight leg raising is positive at about 40° with back pain but not any left leg sciatica. He has no sensory deficit. Knee and Achilles reflexes are intact. He is able to bend forward with difficulty so that his hands come within a foot of the ground.

X-rays show some minor osteoarthritic changes at L5 and L5-S1 otherwise these are pretty much normal for age.

Assessment: Possible herniated disc versus bulging disc.

Recommendation: MRI scan, physical therapy, and Relafen 500 mg 2 tablets q.d. I explained the gastrointestinal complications of Relafen and told him to stop it if he starts getting heartburn.

Plan: We will check him back again after the MRI is done and go from there.

Richard D. McEvoy, MD/bj

8/9/96 Vicodin 5mg ÷ po q 4° prn pain
#30
Flexeril 10mg po TID prn
spasms #30 CB Carrs ER
Spoke to pt about results of
MRI report discussed (F-1)
to Dr. McEvoy. Read Impression
to pt no sx. Pt. advised
pt a greaser will fly report
on 8/19/96

ALASKA DEPARTMENT OF LABOR Alaska Workers' Compensation Board P.O. Box 1149, Juneau, Alaska 99802		PHYSICIAN'S REPORT		AWCB Case Number	
1. Employee's Name (Last, First, Middle Initial) Mr. William C.		2. Insurer Claim No.		3. Injury Date 04, 14, 96	
4. Address [Redacted]		5. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		6. Social Security Number [Redacted]	
7. City Eagle River AK		8. State AK		9. Zip Code 99577	
10. Telephone [Redacted]		11. Business [Redacted]		12. Date Last Injury 8/14/96	
13. Was Body Part Injured Before? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES If yes, when and describe 1977 - Back injury - Strain (partial) spine (lower)		14. Describe Injury and Tell How it happened While Packing, Unloading and lifting boxes at Resident Agency in Fort Smith, AR in preparation for transport to Anchorage, AK. Injured lower back, now pain has progressed into left leg, etc.		15. Have You Seen Any Other Doctor for this Injury? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, list name and address Dr. T. J. Smith, 1111 W 21st St, Anchorage, Alaska	
16. Hospitalized as Patient? Name of Hospital: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		17. YOUR Last Treatment Date (If Date of Completion)		18. Date of Report 4, 18, 96	
19. Describe Injury and Tell How it happened Acute Pain in lower back, spasms down both legs, especially left leg all the way to foot.					
20. ER see attached notes from 8/6/96					
21. Physician's Name and Degree (Print or Type)		22. Physician's Signature		23. Report Date 82-0033318	
24. Address 3548 LaTouche Anchorage AK 99506		25. Telephone 563-3145		26. Date of Report 8/18/96	

**Federal Employee's Notice of
Traumatic Injury and Claim for
Continuation of Pay/Compensation**

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

137852



Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.

Witness: Complete bottom section 16.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle) JR., WILLIAM C.			2. Social Security Number [REDACTED]		
3. Date of birth Mo. Day Yr. 06 07 46	4. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	5. Home telephone (907) 696-7770	6. Grade as of date of injury GS-14 Level Step		
7. Employee's home mailing address (include city, state, and zip code) EAGLE RIVER, ALASKA 99577			8. Dependents <input checked="" type="checkbox"/> Wife, DOB [REDACTED] <input type="checkbox"/> Children under 18 yrs. <input type="checkbox"/> Other		

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
FBI Resident Agency, 2nd Floor, 200 Garrison Avenue, Fort Smith, Arkansas

10. Date injury occurred Mo. Day Yr. 04 14 96	Time 2 : 30 p.m.	11. Date of this notice Mo. Day Yr. 08 12 96	12. Employee's occupation Asst. Special Agent in Charge - FBI
13. Cause of injury (Describe what happened and why) While on duty at the Ft. Smith RA, I was in the process of packing boxes containing files, books, etc., for shipment to my next duty station, Anchorage, AK. A total of 22 boxes were packed and papered for shipping. Each box weighed 25 to 50 lbs. While wrapping/stacking the boxes, I bent over and injured my lower back.			
14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg) Lower back injury with intermittent pain to the right thigh and later extreme back spasms in lower back, left hip and down left leg.		a. Occupation code	b. Type code
		c. Source code	OWCP Use - NO Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

- ☐ b. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5504.
- ☒ a. Sick and/or Annual Leave

Signature of employee or person acting on his/her behalf *William C. Temple*

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. Have your supervisor complete the receipt attached to this form and return it to you for your records.

End of Employee Report

Witness

16. Statement of witness (Describe what you saw, heard, or know about this injury) I was informed by SSRA William C. Temple Jr. on 4/15/96 that he had injured his back while packing in the Resident Agency at Ft. Smith, Arkansas in preparation for his transfer. He stated at that time he did not intend to go to a doctor. On Thursday, 4/18/96, SSRA [REDACTED] advised the muscle spasms in his back had grown worse and that he could not get an appointment with an orthopedic specialist, but he was going to the emergency room at Sparks Hospital. I was later informed by SSRA [REDACTED] that physician diagnosed the injury as a soft tissue injury to the lower back.

Name of witness William C. Temple	Signature of witness <i>William C. Temple</i>	Date signed 8/12/96
Address 10825 Financial Centre Parkway, Ste. 200	City Little Rock	State Arkansas
	Zip Code 72211-3552	

Form CA-1
Rev. Nov. 19

132852



SISTERS OF
PROVIDENCE

PREOPERATIVE DIAGNOSIS: Herniated intervertebral disk, L4-5.

POSTOPERATIVE DIAGNOSIS: Herniated intervertebral disk, L4-5.

PROCEDURE: Partial laminectomy and disk excision, L4-5, left.

SURGEON: Richard D. McEvoy, MD

ASSISTANT SURGEON: Not given.

ANESTHESIOLOGIST: -Michael Norman, MD

ANESTHESIA: General.

DESCRIPTION OF PROCEDURE: The patient was first given a general anesthetic and given Ancel prior to the start of the case. He was turned prone on the Andrews frame. Knees were padded, knees were also placed in TEDs and SCDs. Elbows were padded. Made sure that there was not undue pressure on the ulnar nerves, etc. The hands were beneath the groin area. Chest roll was placed. Neck was in good position and we made sure there was no pressure on the eyes or nose and he was prepped with Betadine soap and solution and draped in the usual fashion.

Straight incision was made, infiltrated with Marcaine with epinephrine and then soft tissues were taken off the L4-5 interspace area. This was identified with a spinal needle and x-ray. The bone was then removed to form a partial laminectomy between L4-5 on the left. Using a Midas-Rex and combination of rongeurs, partial laminectomy was accomplished.

We then took off the ligamentum flavum and identified the large disk herniation. This was then removed in piecemeal fashion with several large pieces of disk and many small pieces. We then irrigated out the space and then retrieved some more disk fragments. Continued to do this until there were no more disk fragments left that we could find in the space. We checked the nerve root and dura with the ball tipped dissector and it was seen to be well decompressed. Wound was then irrigated and fat graft was then placed over the area of the dura and the nerve root.

RDM/002180/dmx

D: 08/27/96 10:32 A

T: 08/28/96 7:21 A

NAME: [REDACTED] William C

MR#: 41-43-60

PHYSICIAN: Richard D McEvoy, MD

CITY/TOWN:

Send to: Richard D McEvoy, MD

OPERATIVE REPORT

DATE OF PROCEDURE: 08/27/96

BILLING #: 80856974

PATIENT TYPE: I

ROOM#: 3W 377-01

Page #1

FC: 9

F-4

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
1111 Third Avenue, Suite 650
Seattle, WA 98101-3211
Telephone s (206) 553-5508



September 23, 1996

(206) 553-5508

File Number: 14-0316826
Date of Injury: 04/14/1996
Employee: WILLIAM C. [REDACTED]

WILLIAM C. [REDACTED] JR.
[REDACTED]
EAGLE RIVER, AK. 99577

Dear Mr. [REDACTED]:

I am writing in reference to your claim for the injury of 04/14/1996, which you sustained while employed by the agency identified below. Your claim is accepted for: SPRAIN LUMBAR REGION

If your injury results in disability for work or the need for medical treatment, you may be eligible to receive continuation of pay (COP) until you recover or return to light duty, up to a maximum of 45 calendar days. If wage loss continues after the expiration of COP, you are eligible to claim disability compensation on Form CA-7. Necessary medical expenses related to the injury will be processed for payment by this office following proper submission of charges.

Enclosed is a pamphlet entitled "Now That Your Claim Has Been Accepted..." which provides information concerning payment of bills, claims for compensation, and other matters pertinent to your claim.

Sincerely,

Lillie Hapton
Claims Examiner

US DEPARTMENT OF JUSTICE
CIP: JOE ANN COMPTON
FEDERAL BUREAU OF INVESTIGATION
ATTN: PERSONNEL COMPENSATION
9TH AND PENNSYLVANIA AVE NW
WASHINGTON DC 20535

CFL

CA1008-0896

F-5

TOTAL P. 82

NOTEPAD AND SYSTEM MESSAGES ANCH FRACTURE & ORTHO CLINIC Page:
 Account... 132852 Name..... ██████████ WILLIAM C
 msg# ty mb days del pl stmt clm# action date. date entered pass cd.

message text.....

2 I 01 0 N 0 08/13/96 JB
 MR. ████████ CALLED. SAID HIS INJURY IS WORK COMP. HE SAID WE SHOULD
 SEND THE BILLS TO FED BUREAU OF INVESTIGATIONS. ATTN CHRIS
 MCWILLIAMS, 101 E 6TH AVE, ANC 99501. HE DOES NOT HAVE A USDL
 CLM # YET, BUT SAID CHRIS SAID TO SEND THE BILLS TO HER AND SHE
 WILL PROCESS THEM.

3 ST 01 0 N 0 08/13/96 JB

ATTN-CHANGE. OLD I NEW C
 OLD FL411111012 NEW 11411111912

message

5 I 01 0 N 0 08/21/96 TR

PER CHRIS MCWILLIAMS (FBI OFFICE: HANDLING THE W/C CASE), AS LONG
 AS DR. MCEVOY FEELS THAT INPT SX ON 082796 CAN NOT WAIT (DUE TO
 RISK OF FURTHER INJURY AND HARDSHIP), AND AS LONG AS THIS
 DETERMINATION HAS BEEN WELL DOCUMENTED (SANDY IN OUR OFFICE TOLD
 CHRIS THAT IF THE NOTES SHE RECEIVED WERE NOT EXPLICIT ENOUGH, SHE
 SHOULD WRITE A LETTER TO DR. MCEVOY REQUESTING FURTHER DOCUMENTA-
 TION), W/C DOES APPROVE THE SURGERY.

9 I 01 0 N 0 09/16/96 JB

PER CHRIS AT FBI, THEY SHOULD HEAR LATER THIS WEEK IF W/C IS
 GOING TO ACCEPT MR BOUNDS' CLM. IF NOT, HIS PRIVATE INS. IS WC...

15 I 01 0 N 0 10/29/96 SF

I RECEIVED A DENIAL FROM USDL NOW ON THE SX THAT HAS ALREADY BEEN
 DONE. I CALLED AND SPOKE WITH CHRIS MCWILLIAMS AT FBI AND SHE IS
 CALLING THE CLAIMS ADJUSTER OVER THERE AND PROMISES SHE WILL GET
 THIS STRAIGHTENED OUT. SHE AGREES THAT USDL IS A PAIN IN THE BUTT!
 I FAXED CHRIS A COPY OF ALL UNPAID DOS AND A COPY OF OUR DENIAL
 FOR SX.

16 I 01 0 N 0 10/29/96 SF

WELL, MOST OF MY DAY HAS BEEN CONSUMED WITH THIS ONE ISSUE HERE
 AT HAND. I JUST RECEIVED A CALL FROM CHRIS AT FBI AND SHE JUST GOT
 OFF THE PHONE WITH USDL. CONTRARY TO ALL OF OUR BELIEFS, USDL IS
 NOW SAYING THEY NEVER AUTHORIZED THE SURG. THEY WILL HOWEVER
 CONSIDER IT IF DR MCEVOY DICTATES A LETTER AS TO WHY THE SURG WAS
 DONE AND WHAT LED HIM TO THIS CONCLUSION. OF COURSE, WE HAVE
 NOTHING IN WRITING PERTAINING TO THAT. SUPPOSEDLY THEY ARE GOING
 TO BE SENDING THE PATIENT THAT REQUEST. BUT NOT THE DR. USDL ALSO
 DENIES HAVING ANY DOCUMENTATION FROM OUR OFFICE ON THIS PT. WHILE

IN THE SAME BREATH, COMPLAINED TO CHRIS ABOUT ALL OF THE PAPERS
 WE SEND WITH OUR BILLING.

F-6

NOTEPAD AND SYSTEM MESSAGES ANCH FRACTURE & ORTHO CLINIC Page:

Account... 132852 Name..... BOUNDS, WILLIAM C.

msg# ty mb days del pl smt clm# action date. date entered pass cd.

message text.....

21 I 01 0 N 0 01/23/97 SF

I HAVE RECALLED DOS 08/24/96 TO USDL. I RECEIVED A DENIAL FROM THEM STATING THAT WE NEVER SENT OF NOTES, WHATEVER!

24 I 01 0 N 0 02/20/97 SF

WELL, WELL, WELL. THIS HAS BEEN QUITE THE EDUCATIONAL EXPERIENCE. I SPOKE WITH BARBARA MCDONALD AT USDL YESTERDAY AND HERES WHAT SHE HAS TO SAY. MR. [REDACTED] SX WAS AUTHORIZED THRU CHRIS AT FBI, BUT THE AUTHORIZATION ACTUALLY NEEDED TO COME FROM USDL. BARB WAS GOING TO MAKE SURE THAT MR. [REDACTED] MEDICAL WOULD BE REVIEWED BY ONE OF THE USDL DRS AND GET BACK TO ME WITHIN THE NEXT WEEK WITH A DEFINITE ANSWER, HOWEVER AT THIS POINT IT IS STILL DENIED. I ALSO HAVE A CALL INTO CHRIS AT FBI TO CALL ME ON THIS. I GUESS AT THIS POINT I WILL WAIT FOR A DEFINITE FROM USDL AND IF IT IS STILL

-- 01 0 N 0 02/20/97 SF

DENIED I WILL PUT THE BALANCE DUE AS THE RESPONSIBILITY OF THE FBI SINCE THEY AUTHORIZED THE SX, AND IF THEY DON'T AGREE TO THAT I WILL NEED TO CONTACT MR BOUNDS AND MAKE THIS HIS RESPONSIBILITY SINCE HIS PRIVATE WON'T TOUCH IT. LESSON LEARNED: NEVER SEND W/C BILLINGS TO ANY FEDERAL AGENCY, ONLY SEND TO USDL AND WILL DEAL DEAL WITH THEM DIRECTLY.

03/03/97 SF

KRIS FROM FBI CALLED TO SAY THAT MR [REDACTED] CAME INTO WORK WITH A LETTER DATED 02/25/97 STATING THAT USDL HAS AUTHORIZED THE SX AND THAT WE SHOULD BE EXPECTING PAYMNET SOON.

03/20/97 SF

I SPOKE WITH CHRIS AT FBI TODAY AND SHE SAID THAT THE HOSPITAL WAS JUST PAID ON 03/18/97 AND THAT SHE WOULD CHECK WITH THEM AND THAT WE S/B RECEIVING PAYMENT SOON.

(F-7)

NOTEPAD AND SYSTEM MESSAGES ANCH FRACTURE & ORTHO CLINIC Page:

Account... 132852 Name..... BOUNDS, WILLIAM C.

msg#	ty	mb	days	del	pl	stmt	clm#	action	date.	date entered	pass	cd
message text.....												
31	I		01			0	N		0	04/07/97	SF	

I CALLED AND LEFT A MSG FOR BARBARA MCDOBALD AT OWCP RE: SX BAL.

NOTEPAD AND SYSTEM MESSAGES ANCH FRACTURE & ORTHO CLINIC Page:

Account... 132852 Name..... BOUNDS, WILLIAM C.

msg#	ty	mb	days	del	pl	stmt	clm#	action	date.	date entered	pass	cd
message text.....												
32	I		01			0	N		0	04/09/97	SF	

I SPOKE WITH BARBARA MCDONALD AT USDL TODAY AND SHE SAID SHE REMEMBERS GETTING OUR SX CHARGES, HOWEVER THE FOLKS THAT W/B PAYING THIS CLAIM WOULD EITHER BE DEBRA CORNEL OR ROD PARKER AND SHE WAS GOING TO GET WITH THEM TODAY TO FIND OUT WHAT THE HOLD UP IS AND HAVE ONE OF THEM CALL ME.

NOTEPAD AND SYSTEM MESSAGES ANCH FRACTURE & ORTHO CLINIC Page:

Account... 132852 Name..... BOUNDS, WILLIAM C.

msg#	ty	mb	days	del	pl	stmt	clm#	action	date.	date entered	pass	cd
message text.....												
33	I		01			0	N		0	04/09/97	SF	

I HAVE RECEIVED A CALL FROM RODNEY BARKER AT USDL, HE SAID HE DID HAVE THE SX CHARGES AND THAT HE WOULD SEND THEM IN FOR PROCESSING AND THAT WE SHOULD RECEIVE PAYMENT IN LESS THAN A MONTH. LETS HOPES XO.

NOTEPAD AND SYSTEM MESSAGES ANCH FRACTURE & ORTHO CLINIC Page:

Account... 132852 Name..... BOUNDS, WILLIAM C.

msg#	ty	mb	days	del	pl	stmt	clm#	action	date.	date entered	pass	cd
message text.....												
34	I		01			0	N		0	04/11/97	SF	

CHRIS FROM FBI ASKED ME TO CALL HER IF WE DO NOT RECEIVE SX CHARGE IN THE NEXT 30 DAYS.

-----S T A T E M E N T O F A C C O U N T-----

For the period 08/05/96 Thru 05/30/97
 ANCH FRACTURE & ORTHO CLINIC
 3260 PROVIDENCE DR., SUITE 200
 ANCHORAGE, AK 99508
 907-563-3145

Statement date: 05/05/99
 TO: BOUNDS, WILLIAM C.
 20194 CONSTITUTION DR
 EAGLE RIVER, AK 99577

SF PAGE

Account# 132852 Ins prov# Prov# IRS# 92-0039318
 Tel: 907-696-7770 Cht# 132852 Birth: 06/07/46 SS#: 429-86-8343

DATE	PROV	PL	NAME	SERV	SERVICE DESCRIPTION	ICDA	AMOUNT
Claim # 1							
08/05/96	55	DO	WILLIAM	99203	NEW PATIENT OFFICE VISIT	7242	120.00
08/05/96	55	DO	WILLIAM	72100	LUMBAR XRAY (3V)	7242	106.00
10/30/96	55		WILLIAM	PWC	(PAYMENT) BY WORKERS' COMP (pg E-12)		163.00-
					USDL check date 10/21/96		
05/30/97	55		WILLIAM	COWC	OUT OF STATE FEE SCHEDULE	write-off	63.00-
*****TOTAL OF CLAIM TRANS *****							\$.00
Claim # 2							
08/04/96	45	DO	WILLIAM	99213	ESTABLISHED PATIENT VISI	72210	72.00
11/15/96	45		WILLIAM	PWC	(PAYMENT) BY WORKERS' COMP (pg E-12)		58.00-
					USDL check date 10/28/96		
11/15/96	45		WILLIAM	COWC	OUT OF STATE FEE SCHEDULE	write-off	14.00-
*****TOTAL OF CLAIM TRANS *****							\$.00
Claim # 3							
08/14/96	1000	DO	WILLIAM	97035	ULTRASOUND THERAPY (15 M	7242	25.00
08/14/96	1000	DO	WILLIAM	99213	ESTABLISHED PATIENT VISI	7242 not paid	72.00
08/16/96	1000	DO	WILLIAM	97014	ELECTRICAL STIM, UNATTEND	7242	30.00
08/16/96	1000	DO	WILLIAM	97035	ULTRASOUND THERAPY (15 M	7242	25.00
08/16/96	1000	DO	WILLIAM	97250	MYOFASCIAL RELEASE	7242	63.00-
10/30/96	1000		WILLIAM	PWC	(PAYMENT) BY WORKERS' COMP (pg E-12)		114.00-
					USDL check date 10/21/96		
05/30/97	1000		WILLIAM	COWC	OUT OF STATE FEE SCHEDULE	write-off	101.00-
*****TOTAL OF CLAIM TRANS *****							\$.00
Claim # 4							
08/19/96	55	DO	WILLIAM	99212	ESTABLISHED PATIENT VISI	72210	51.00
10/30/96	55		WILLIAM	PWC	(PAYMENT) BY WORKERS' COMP (pg E-12)		41.00-
					USDL check date 10/21/96		
05/30/97	55		WILLIAM	COWC	OUT OF STATE FEE SCHEDULE	write-off	10.00-
*****TOTAL OF CLAIM TRANS *****							\$.00
Claim # 5							
08/19/96	1000	DO	WILLIAM	97035	ULTRASOUND THERAPY (15 M	7242	25.00
08/19/96	1000	DO	WILLIAM	97250	MYOFASCIAL RELEASE	7242	63.00

(F-9)

-----STATEMENT OF ACCOUNT-----

For the period 08/05/96 Thru 05/30/97
 ANCH FRACTURE & ORTHO CLINIC
 3260 PROVIDENCE DR., SUITE 200
 ANCHORAGE, AK 99508
 907-563-3145

Statement date: 05/05/99
 TO: BOUNDS, WILLIAM C.
 20194 CONSTITUTION DR
 EAGLE RIVER, AK 99577

SF PAGE 2

Account# 132852 Ins prov# Prov# IRS# 92-0039318
 Tel: 907-696-7770 Cht# 132852 Birth: 06/07/46 SS#: 429-86-8343

DATE	PROV	PL NAME	SERV	SERVICE DESCRIPTION	ICDA	AMOUNT
08/21/96	1000	DO WILLIAM	97014	ELECTRICAL STIM, UNATTEND	7242	30.00
08/21/96	1000	DO WILLIAM	97035	ULTRASOUND THERAPY (15 M	7242	25.00
08/21/96	1000	DO WILLIAM	97250	MYOFASCIAL RELEASE	7242	63.00
10/30/96	1000	WILLIAM	PWC	(PAYMENT) BY WORKERS' COMP		164.00
				USDL		
11/15/96	1000	WILLIAM	COWC	OUT OF STATE FEE SCHEDULE	write-off	42.00
				DOS 8/19-21		
*****TOTAL OF CLAIM TRANS *****						\$.00

Claim # 6
 08/26/96 55 DO WILLIAM 99023 PRE-OP VISIT; ONE DAY PRI 72210 .00
 *****TOTAL OF CLAIM TRANS ***** \$.00

Claim # 7
 08/27/96 55 IH WILLIAM 63030 LAMINOTOMY 72210 4100.00
 04/29/97 55 WILLIAM PWC (PAYMENT) BY WORKERS' COMP (pg E-17) 2102.00
 USDL check date 4/21/97
 05/30/97 55 WILLIAM COWC OUT OF STATE FEE SCHEDULE write-off 1998.00
 *****TOTAL OF CLAIM TRANS ***** \$.00

Claim # 8
 09/04/96 55 DO WILLIAM 99024 POSTOPERATIVE FOLLOW UP 72210 .00
 *****TOTAL OF CLAIM TRANS ***** \$.00

Claim # 9
 09/09/96 1000 DO WILLIAM 97110 THERAPEUTIC EXERCISE (15 7242 90.00
 09/11/96 1000 DO WILLIAM 97110 THERAPEUTIC EXERCISE (15 7242 90.00
 10/30/96 1000 WILLIAM PWC (PAYMENT) BY WORKERS' COMP 140.00
 USDL
 11/15/96 1000 WILLIAM COWC OUT OF STATE FEE SCHEDULE write-off 40.00
 DOS 9/9-11
 *****TOTAL OF CLAIM TRANS ***** \$.00

Claim # 10
 09/13/96 2000 DO WILLIAM 97110 THERAPEUTIC EXERCISE (15 7242 90.00
 10/30/96 2000 WILLIAM PWC (PAYMENT) BY WORKERS' COMP (pg E-14) 70.00
 USDL check date 10/21/96

F-10

-----STATEMENT OF ACCOUNT-----
 For the period 08/05/96-Thru 05/30/97
 ANCH FRACTURE & ORTHO CLINIC
 3260 PROVIDENCE DR., SUITE 200
 ANCHORAGE, AK 99508
 907-563-3145

Statement date: 05/05/99
 TO: BOUNDS, WILLIAM C.
 20194 CONSTITUTION DR
 EAGLE RIVER, AK 99577

SF PAGE 3

Account# 132852 Ins prov# Prov# IRS# 92-0039318
 Tel: 907-696-7770 Cht# 132852 Birth: 06/07/46 SS#: 429-86-8343

DATE	PROV PL NAME	SERV	SERVICE DESCRIPTION	ICDA	AMOUNT
11/15/96	2000 WILLIAM	COWC	OUT OF STATE FEE SCHEDULE DOS 9/13	write-off	20.00-
*****TOTAL OF CLAIM TRANS *****					\$.00

Claim # 11	09/16/96 55 DO WILLIAM	99024	POSTOPERATIVE FOLLOW UP	72210	.00
*****TOTAL OF CLAIM TRANS *****					\$.00

Claim # 12	09/16/96 2000 DO WILLIAM	97110	THERAPEUTIC EXERCISE (15 7242		90.00
	09/18/96 2000 DO WILLIAM	97035	ULTRASOUND THERAPY (15 M 7242		25.00
	09/18/96 2000 DO WILLIAM	97112	NEUROMUSCULAR RE-EDUCATI 7242		44.00
	09/18/96 2000 DO WILLIAM	97250	MYOFASCIAL RELEASE 7242		63.00
	11/01/96 2000 WILLIAM	PWC	PAYMENT BY WORKERS' COMP (page 15)		174.00-
		USDL	check date 10/28/96		
	11/15/96 2000 WILLIAM	COWC	OUT OF STATE FEE SCHEDULE	write-off	48.00-
*****TOTAL OF CLAIM TRANS *****					\$.00

Claim # 13	09/20/96 1000 DO WILLIAM	97110	THERAPEUTIC EXERCISE (15 7242		90.00
	11/01/96 1000 WILLIAM	PWC	PAYMENT BY WORKERS' COMP (page 15)		70.00-
		USDL	check date 10/28/96		
	11/15/96 1000 WILLIAM	COWC	OUT OF STATE FEE SCHEDULE	write-off	20.00-
*****TOTAL OF CLAIM TRANS *****					\$.00

Claim # 14	09/30/96 4000 DO WILLIAM	97110	THERAPEUTIC EXERCISE (15 7242		90.00
	11/14/96 4000 WILLIAM	PWC	PAYMENT BY WORKERS' COMP (page 16)		70.00-
		USDL	check date 11/4/96		
	12/17/96 4000 WILLIAM	COWC	OUT OF STATE FEE SCHEDULE	write-off	20.00-
*****TOTAL OF CLAIM TRANS *****					\$.00

Claim # 15	12/22/96 4000 DO WILLIAM	97110	THERAPEUTIC EXERCISE (15 7242		90.00
	14/96 4000 WILLIAM	PWC	PAYMENT BY WORKERS' COMP (page 16)		70.00-
		USDL	check date 11/4/96		

(F-11)

-----S T A T E M E N T O F A C C O U N T-----

For the period 08/05/96 Thru 05/30/97
 ANCH FRACTURE & ORTHO CLINIC
 3260 PROVIDENCE DR., SUITE 200
 ANCHORAGE, AK 99508
 907-563-3145

Statement date: 05/05/99 SF PAGE 4
 TO: BOUNDS, WILLIAM C.
 20194 CONSTITUTION DR
 EAGLE RIVER, AK 99577

Account# 132852 Ins prov# Prov# IRS# 92-0039318
 Tel: 907-696-7770 Cht# 132852 Birth: 06/07/46 SS#: 429-86-8343

DATE	PROV PL NAME	SERV	SERVICE DESCRIPTION	ICDA	AMOUNT
12/17/96	4900 WILLIAM	COWC	OUT OF STATE FEE SCHEDULE	<u>write-off</u>	20.00-
*****TOTAL OF CLAIM TRANS *****					\$.00
Claim # 16					
10/04/96	1000 DO WILLIAM	97110	THERAPEUTIC EXERCISE (15 7242		45.00
11/14/96	1000 WILLIAM	PWC	<u>PAYMENT</u> BY WORKERS' COMP (pg E-16)		35.00-
		USDL	<u>check date 11/1/96</u>		
12/17/96	1000 WILLIAM	COWC	OUT OF STATE FEE SCHEDULE	<u>write-off</u>	10.00-
*****TOTAL OF CLAIM TRANS *****					\$.00
Claim # 17					
10/14/96	55 DO WILLIAM	99024	POSTOPERATIVE FOLLOW UP 72210		.00
*****TOTAL OF CLAIM TRANS *****					\$.00
Claim # 18					
12/18/96	55 DO WILLIAM	99024	POSTOPERATIVE FOLLOW UP 72210		.00
*****TOTAL OF CLAIM TRANS *****					\$.00
Claim # 19					
03/26/97	55 DO WILLIAM	99213	ESTABLISHED PATIENT VISI 72210		73.00
05/19/97	55 WILLIAM	PWC	<u>PAYMENT</u> BY WORKERS' COMP (pg E-18)		65.00-
		USDL	<u>check date 5/12/97</u>		
05/30/97	55 WILLIAM	COWC	OUT OF STATE FEE SCHEDULE	<u>write-off</u>	8.00-
*****TOTAL OF CLAIM TRANS *****					\$.00
*****TOTAL OF CLAIMS *****					\$.00

(F-12)

132852

United States Treasury 15-51 M 088,114,582
000

Check No. 2036 97363745

10 21 96 8 PHILADELPHIA, PA L920039318A3 M2 OWCP-HISC. 0114961017 16152001

Pay to the order of ANCHORAGE FRAC AND ORTHOPEDIC CLN01
3268 PROVIDENCE DRIVE NUR 200
ANCHORAGE AK 99508

\$****318.00
VOID AFTER ONE YEAR

PER ENCLOSED MAILING NOTICE

2036 1# 00000005181: 973637456# 011096

NOTICE TO CHECK RECIPIENT TREASURY FINANCIAL MANAGEMENT SERVICE TFS FORM 300 (Rev.)

VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLN01 VENDOR ID NUMBER: L920039318A3

AGENCY NAME AND BILLING ADDRESS: US DEPT OF LABOR, ESA/OWCP
1111 3RD AVE
SUITE 650
SEATTLE, WA. 98101-3211

U.S. TREASURY REG. FINANCIAL CENTER: PHILADELPHIA, PA

CHECK NUMBER: 2036-97363745 CHECK AMOUNT: \$****318.00 CHECK DATE: 10-21-96

THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.

PAYMENT IDENTIFICATION DATA:

DATE	AMOUNT	UNPAID	PAID	EXPLANATION
140378826	W BOUNDS	132852	41.55	3-114.52
13285200	08/16-08/16/96	18.00	18.00	103-88
13285200	08/16-08/16/96	4.00	4.00	120-88
13285200	08/16-08/16/96	25.00	25.00	120-88
13285200	08/16-08/16/96	6.00	6.00	120-88
13285200	08/16-08/16/96	34.00	34.00	120-88
13285200	08/16-08/16/96	5.00	5.00	120-88
13285200	08/16-08/16/96	20.00	20.00	120-88
13285200	08/16-08/16/96	51.00	51.00	120-88

AGENCY SCHEDULE NUMBER: 0114961017
AGENCY TELEPHONE NUMBER: 206-553-5508

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS OR TELEPHONE NUMBER INDICATED ABOVE.

F-13

United States Treasury 15-51 000 M 088,114,584

Check No. 10 21 96 4 PHILADELPHIA, PA 2036 97363747
L920039318A5 M2 OWCP-MISC. 0114961017 16152001

Pay to the order of ANCHORAGE FRAC AND ORTHOPEDIC CLN01
3260 PROVIDENCE DRIVE NUM 200
ANCHORAGE AK 99508 \$*****70*00

VOID AFTER ONE YEAR

PER ENCLOSED MAILING NOTICE

⑈ 2036 1⑈ ⑆000000518⑆ 973637478⑈ 011096

NOTICE TO CHECK RECIPIENT		TREASURY-FINANCIAL MANAGEMENT SERVICE TFS FORM 3039 (Rev.)	
VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLN01		VENDOR I.D. NUMBER: L920039318A5	
AGENCY NAME AND BILLING ADDRESS: US DEPT OF LABOR, ESA/OWCP 1111 3RD AVE SUITE 650 SEATTLE, WA. 98101-3211		US TREASURY REG. FINANCIAL CENTER: PHILADELPHIA, PA	
		CHECK NUMBER: 2036-97363747	CHECK AMOUNT: \$*****70.00
		CHECK DATE: 10-21-96	
<p>THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.</p> <p>140314826 - W BOUNDS *132852 - (10) 13285208 - 09/13-09/13/96 98.00 - 20.00 - 70.00</p>			
		AGENCY SCHEDULE NUMBER: 0114961017	
		AGENCY TELEPHONE NUMBER: 206-553-5508	

NON NEGOTIABLE

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS OR TELEPHONE NUMBER INDICATED ABOVE.

(F-14)

United States Treasury 15-51 M 088,128,033
600

Check No.
10 28 96 65 PHILADELPHIA, PA 2036 97513705
L920039318A8 M2 OWCP-HISC. 0114961024 16152001

Pay to
the order of
ANCHORAGE FRAC AND ORTHOPEDIC CLND1
3260 PROVIDENCE DRIVE NUM 200
ANCHORAGE AK 99508

\$**302*00**
VOID AFTER ONE YEAR

PER ENCLOSED MAILING NOTICE

2036 11# 10000005184: 975137053# 011096

NOTICE TO CHECK RECIPIENT TREASURY FINANCIAL MANAGEMENT SERVICE TFS FORM 3028 (Rev. 1)

VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLND1	VENDOR ID. NUMBER: L920039318A8
AGENCY NAME AND BILLING ADDRESS: US DEPT OF LABOR, ESA/OWCP 1111 3RD AVE SUITE 650 SEATTLE, WA. 98101-3211	U.S. TREASURY REG. FINANCIAL CENTER: PHILADELPHIA, PA CHECK NUMBER: 2036-97513705 CHECK AMOUNT: \$****302.00 CHECK DATE: 10-28-96

THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT. (1)-58.00 ALC 16-15-2001

PAYMENT IDENTIFICATION DATA	W BOUNDS	(3)-70.00	(2)-174.00
140316826	08/14-08/14/96	72.00	58.00
13282208	09/18-09/18/96	70.00	20.00
13282200	09/18-09/18/96	63.00	12.00
13282200	09/18-09/18/96	44.00	14.00
13282200	09/18-09/18/96	25.00	20.00
13282290	09/20-09/20/96	90.00	20.00

AGENCY SCHEDULE NUMBER: 0114961024
AGENCY TELEPHONE NUMBER: 206-553-5508

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS OR TELEPHONE NUMBER INDICATED ABOVE.

F-15

COWC

133

United States Treasury 16-51
000 M 088,422,073

Check No. 2038 26357770

11 04 96 7 PHILADELPHIA, PA 2038 26357770
L920039318A5 M2 OWCP-MISC. 0114961031 16152001

Pay to the order of ANCHORAGE FRAC AND ORTHOPEDIC CLN01
3260 PROVIDENCE DRIVE NUM 200
ANCHORAGE AK 99508 \$****175*00
VOID AFTER ONE YEAR

PER ENCLOSED MAILING NOTICE

⑈ 20383⑈ ⑆000000518⑆ 26357770⑈ 011496

NOTICE TO CHECK RECIPIENT TREASURY FINANCIAL MANAGEMENT SERVICE TFS FORM 3020 (Rev.)

VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLN01 VENDOR I.D. NUMBER: L920039318A5

AGENCY NAME AND BILLING ADDRESS: US DEPT OF LABOR, ESA/OWCP 1111 3RD AVE SUITE 650 SEATTLE, WA, 98101-3211

FINANCIAL CENTER: PHILADELPHIA, PA

CHECK NUMBER: 2038-26357770 CHECK AMOUNT: \$****175.00 CHECK DATE: 11-04-96

AGENCY SCHEDULE NUMBER: 0114961031

AGENCY TELEPHONE NUMBER: 206-553-5508

THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.

140316826 W BOUNDS *132852 (15)-70.02 (16)-35.00

11283200 08/30-08/30/96 70.00 35.00 35.00

13283200 10/02-10/02/96 90.00 30.00 60.00

13283200 10/04-10/04/96 45.00 15.00 30.00

NON-NEGOTIABLE

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS OR TELEPHONE NUMBER INDICATED ABOVE.

COWC CL 14 \$20.00
32852 CL 15 \$20.00
CL 16 \$10.00

12/10/96

F-116

United States Treasury 15-51 M 090,486,C12

Check No. 2038 50164322

Pay to the order of ANCHORAGE FRAC AND ORTHOPEDIC CLN01
3260 PROVIDENCE DRIVE NUM 200
ANCHORAGE AK 99508

\$***2102*00

VOID AFTER ONE YEAR

PER ENCLOSED MAILING NOTICE

⑈ 20383⑈ ⑆000000518⑆ 50164322⑈ 010497

NOTICE TO CHECK RECIPIENT		TREASURY FINANCIAL MANAGEMENT SERVICE		TFS FORM 3029 (Rev.)	
VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLN01		VENDOR ID NUMBER: L920039318A1			
AGENCY NAME AND BILLING ADDRESS: US DEPT OF LABOR, ESA/OWCP 1111 3RD AVE SUITE 650 SEATTLE, WA. 98101-3211		U.S. TREASURY REG. FINANCIAL CENTER: PHILADELPHIA, PA			
		CHECK NUMBER: 2038-50164322	CHECK AMOUNT: \$***2102.00	CHECK DATE: 04-21-97	
THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.				AGENCY SCHEDULE NUMBER: 0114970417	
				AGENCY TELEPHONE NUMBER: 206-553-5508	
<p>140316826 W BOUNDS 122852 08/23-08/27/96 \$ 100.00 \$ 298.00 \$ 102.00</p> <p>NON NEGOTIABLE</p> <p>122852 08/23-08/27/96 \$ 100.00 \$ 298.00 \$ 102.00</p>					

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS OR TELEPHONE NUMBER INDICATED ABOVE.

(F-17)

United States Treasury 15-51 M 092,179,284
000

Check No. 05 12 97 3 PHILADELPHIA, PA 2038 29195392
L920039318A7 M2 OWCP-MISC. 0114970508 16152001

Pay to the order of ANCHORAGE FRAC AND ORTHOPEDIC CLNU1
3260 PROVIDENCE DRIVE NUM 200
ANCHORAGE AK 99508 \$*****65*00

VOID AFTER ONE YEAR

PER ENCLOSED MAILING NOTICE

20383# 40000005184 291953926# 010597

NOTICE TO CHECK RECIPIENT TREASURY FINANCIAL MANAGEMENT SERVICE TFS FORM 309 (Rev.)

VENDOR NAME: ANCHORAGE FRAC AND ORTHOPEDIC CLNU1 VENDOR ID. L920039318A7
NUMBER: 0114970508

AGENCY NAME: US DEPT OF LABOR, ESA/OWCP U.S. TREASURY REG. PHILADELPHIA, PA
AND BILLING 1111 3RD AVE
ADDRESS: SUITE 650 FINANCIAL CENTER
SEATTLE, WA. 98101-3211

CHECK NUMBER 2038-29195392 CHECK AMOUNT \$*****65.00 CHECK DATE 05-12-97

THIS PAYMENT IS FOR FECA BILLS. FOLLOWING IS THE CASE NUMBER, CLAIMANT NAME, INVOICE NUMBER OR DATE, SERVICE DATES, AMOUNTS BILLED, UNPAID, PAID AND AN EXPLANATION OF ANY UNPAID AMOUNT.

140314826 W BOUNDS 03/26-03/26/97 73.00 8.00 65.00
132852

AGENCY SCHEDULE NUMBER 0114970508
AGENCY TELEPHONE NUMBER 206-553-5508

NON NEGOTIABLE

PLEASE DIRECT ANY INQUIRIES CONCERNING THIS PAYMENT TO THE AGENCY AT THE ADDRESS OR TELEPHONE NUMBER INDICATED ABOVE.

F-18

132852

FISCAL OFFICER
U.S. DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMPENSATION PROGRAMS
1111 THIRD AVENUE-SUITE 650
SEATTLE WA 98101-3211

10/09/1996

CASE # : 140316826
CLAIMANT: BOUNDS, WILLIAM C, JR

ANCHORAGE FRAC AND ORTHOPEDIC CLN
3260 PROVIDENCE DRIVE NUM 200
ANCHORAGE, AK 99508

PAYEE TAX IDENTIFICATION NUMBER: 920039318

THE FOLLOWING EXPLANATION IS PROVIDED FOR BENEFITS CLAIMED UNDER THE
FEDERAL EMPLOYEES' COMPENSATION ACT:

INVOICE # 13285200 RECEIVED 10/07/1996 BILL ID 6J0699001
BILL TOTAL \$4,100.00 PROCESSED 10/09/1996

SERVICE DATES FROM - TO	PROCEDURE CODE	UNITS	CHARGE	EOB MESSAGES
08/27/1996-08/27/1996	63030	001	\$4,100.00	704

704 BILLED SERVICE(S) NOT RELATED TO THE ACCEPTED CONDITION(S) IN
THIS CLAIM.

A COPY OF THIS NOTICE SHOULD BE PLACED ON TOP OF ANY MATERIALS
SUBMITTED IN RESPONSE TO THIS NOTICE.

QUESTIONS ON THIS NOTICE OR RESUBMITTED BILLINGS MAY BE SENT WITHIN 30
DAYS TO THE ABOVE ADDRESS.

IF YOU DISAGREE WITH THE DENIALS IN THIS NOTICE, RESUBMIT A BILL FOR
THE UNPAID CHARGES, AND A FULL, DETAILED EXPLANATION AS TO WHY THE
BILL SHOULD BE PAID.

PAYMENTS ARE MADE UNDER SEPARATE COVER AND ARE ACCOMPANIED BY AN
EXPLANATION.



**Anchorage
Fracture &
Orthopedic
Clinic**

3260 PROVIDENCE DR., SUITE 300
ANCHORAGE, ALASKA 99528
(907) 563-3145 FAX 561-8314

•DECLAN R. NOLAN, M.D.
•RICHARD W. GARNER, M.D.
•THOMAS F. VASILEFF, M.D.
•RICHARD D. MCEVOY, M.D.
•ADRIAN B. RYAN, M.D.
•DAVIS C. PETERSON, M.D.
•STEPHEN S. TOWER, M.D.
•LESLIE R. DEAN, M.D.

•Fellows American Academy of Orthopedic Surgeons

November 4, 1996

Ms. Lillie Hayden, Claims Representative
Employment Standards Administration
Office of Workers' Compensation Programs
1111 Third Avenue, Suite 650
Seattle, WA. 98101-3211

RE: [REDACTED] William
OUR FILE: CA-132852
EMP: FBI
INI: 4-14-96
YOUR FILE: 14-0316826

Dear Sir or Madame:

Mr. [REDACTED] underwent a laminectomy and disc excision for a herniated intervertebral disc at the L4-L5 level on the level on the left on August 27, 1996. This surgery was necessary because the disc was impinging on the spinal canal and pinching a nerve causing him severe pain, decreased sensation, and loss of ankle reflex as well as muscle weakness of the extensor hallucis longus and extensor digitorum communis on the left foot. Surgery is the most common solution for this problem.

The patient's problem began while packing, wrapping, and lifting boxes at his resident agency in Ft. Smith, Arkansas in preparation for transfer to Anchorage, Alaska.

Sincerely,

Richard D. McEvoy, MD

RDM:bj

cc to: William C. [REDACTED]
FBI, Anchorage

F-20

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
1111 Third Avenue, Suite 650
Seattle, WA 98101-3211
Telephone # (206) 553-5508



February 25, 1997

(206) 553-5508

File Number: 14-0316826
Date of Injury: 04/14/1996
Employee: WILLIAM C. [REDACTED]

WILLIAM C. [REDACTED] JR
[REDACTED]
EAGLE RIVER, AK. 99577

Dear Mr. [REDACTED]:

This is a letter to update your accepted condition for your work injury of April 14, 1996 to herniated disc L4-5. Laminectomy and disc excision surgery performed August 27, 1996 is authorized after the fact.

Please see the enclosed Publication CA 14 dated April 1996 for additional information about your injury.

Sincerely,

LILLIE HAYDEN
Claims Examiner

Enclosure(s)

US DEPARTMENT OF JUSTICE
CTF: JOE ANN COMPTON
FEDERAL BUREAU OF INVESTIGATION
ATTN: PERSONNEL COMPENSATION
9TH AND PENNSYLVANIA AVE NW
WASHINGTON DC 20535

CFL *Dr. McE...*

CA9999

F-21

ALASKA ECONOMIC

AUGUST 1998

TRENDS

Tony Knowles, Governor

State of Alaska

Alaska Department of Labor

The Trends 100:

ALASKA'S LARGEST PRIVATE EMPLOYERS 1997

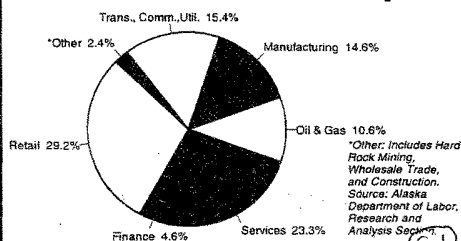
BY NEAL FRIED AND BRIGITTA WINDISCH

After its explosive growth of the early to mid-1990s, the retail industry apparently is taking a breather. Nevertheless, in 1997, Alaska's retailers still employed nearly 30 percent of all Trends 100 workers, providing the single largest piece of this employment pie.

Inside:

13 • Alaska's Economy Heats Up

Retail Employment Dominates Among Trends 100 Group



Employment in all of the airlines grew

Alaska Airlines was one of seven airlines that made 1997's list of 100 largest employers. All of the *Trends* 100 airlines added employment in 1997, so a majority of them also moved up the list. This result is not surprising, given the present dynamics of this industry.

The financial group loses one

For the first time since 1989, financial institutions on the *Trends* 100 list changed. Key Bank's downsizing dropped it off the list entirely. Two banks and one credit union, National Bank of Alaska, First National Bank of Anchorage and Alaska USA Federal Credit Union, still remain on the list of the state's largest employers.

Trends 100 employers are ubiquitous in Alaska

Even though nearly two-thirds of the *Trends* 100 employers have their largest work site or headquarters in Anchorage, fewer than 15 operate exclusively in the state's largest city. For example, National Bank of Alaska is headquartered in Anchorage but has branches in 28 other communities around the state. Alaska's largest employers can be found in all regions and sizes of communities. None of the 12 fish processors, nor either of the two timber firms, is based in Anchorage. Akutan, a small community in the Aleutian Islands, hosts Trident Seafood Corporation's largest processing plant.

Alaska's Top 10 Employers Including the Public Sector

11

Rank	Name of Organization	1997 Employment	Headquarters or Largest Worksite
1	Federal government	17,339	Anchorage
2	State of Alaska	15,791	Juneau
3	University of Alaska	5,434	Fairbanks
4	Anchorage School District	5,248	Anchorage
5	Municipality of Anchorage	3,553	Anchorage
6	Carr Gottstein Foods	3,192	Anchorage
7	Providence Alaska Medical Center	2,844	Anchorage
8	Fred Meyer	1,925	Anchorage
9	Fairbanks North Star School Dist.	1,706	Fairbanks
10	ARCO Alaska	1,526	Anchorage

Source: Alaska Department of Labor, Research and Analysis Section.

Top 10 changes when including the public sector

When the public sector is included, the list of the state's largest employers changes dramatically. (See Exhibit 11.) With this change, only four private sector employers rank in the Top Ten: Carr Gottstein Foods, Providence Alaska Medical Center, Fred Meyer and ARCO Alaska. This result should not be surprising, since 27 percent of the state's workforce is employed in the public sector, and public sector organizations tend to be large. Therefore, the public sector,

including the federal government, state government, the university, the Anchorage School District and the Municipality of Anchorage, heads this list. As the public sector's share of the workforce continues to decline, however, private sector employers are becoming a stronger force in Alaska's economy.

Mr. HORN. Let me just question you on one point. I want to make sure I understand on the chart, the write-off. Is that essentially your agency's write-off on it?

Ms. BALEN. That's the amount that we have to write off, because you cannot bill Federal worker for the difference in what the USDOL pays and what our charges are. So, yes.

Mr. HORN. That mounts up to quite a bit. Of these particular operations you note here, was there ever any attempt to get the agency to change the fee, particularly based on the cost of living in Alaska, which is probably the highest in the United States, isn't it?

Ms. BALEN. Pretty close.

Mr. HORN. If not the State of Washington. The two of them usually have been the highest cost of living.

So have they ever adjusted their fees based on concerns from you?

Ms. BALEN. They have never adjusted the fees, to my knowledge. We have tried appealing, and in fact we appeal to commercial insurances periodically using some of the documentation that I have attached in my statement. An appeal to the USDOL is typically a waste of time, though. The only response we get is that's their fee schedules and that's it.

Mr. HORN. Well, I thank you. That's a very helpful document and series.

And we will now move to Mr. John Riordan, first vice president, Council 220, American Federation of Government Employees.

Mr. RIORDAN. Mr. Chairman and members of subcommittee.

Thank you for this opportunity to address the topic of customer service at the Office of Workers' Compensation Programs by the Department of Labor.

My name is John Riordan. I am first vice president of the American Federation of Government Employees, AFL-CIO, Council 220 which represents approximately 25,000 Social Security employees in field offices throughout the country. I have been employed by the Social Security Administration for over 25 years. And as a union official, I have represented many SSA employees that have been injured on the job and who have applied for workers' compensation.

I am currently representing four employees. None of these employees are receiving compensation benefits at present, although they applied for benefits many months ago. I encounter difficulties contacting agents because of the voice mail system. You are no longer able to speak with an agent. Instead I have to leave voice recorded messages. When I receive no response, I have to write to them even though I work in the same building, 201 Varick Street, New York City, where they are located.

They imposed a policy restricting visitors to their offices a couple of years ago. I want to recount briefly an incident which occurred on September 16, 1996, when I accompanied a customer who wanted to deliver some documents to the OWCP office at 201 Varick Street. The customer who I accompanied is Dianne McGuinness who testified earlier before the subcommittee.

Ms. Diane McGuinness came to my office and reviewed some of the documents she wanted to submit to OWCP. Ms. McGuinness wanted to deliver her appeal of the denial of the continuation of her workers' compensation benefits. I was, at that time, president

of AFG Local 3369 which represents Social Security field office employees in New York City, Long Island, and Westchester County. We took the elevator from the 11th floor to the 7th floor where OWCP is located. The door to the office was locked and there was no mail slot.

While searching for a place to deliver the appeal, a man appeared at the end of a long corridor and started shouting. I tried to ignore him, but Ms. McGuinness said to me that he was shouting at us. As the man approached he was still shouting, indeed it was directed toward us.

We attempted to explain to him why we were there, but he didn't stop talking so he could hear our response. He told us to leave the building immediately. He said we had to have an appointment to be there. I told him that I had called to make an appointment earlier, but no one responded to our calls. Ms. McGuinness and I told him that we were Federal employees. The man responded that he didn't care whether or not we were Federal employees and that he would call the security guards to remove us if we did not leave.

Ms. McGuinness had made an appointment through the Senator's office to deliver the appeal, but she was not able to tell the man this because he would not let her talk. The man was visibly upset and disturbed by our presence. Ms. McGuinness asked him if he were Mr. Kenneth Hamlett, the New York Regional Director OWCP, and he said he was. Ms. McGuinness introduced herself to him and Mr. Hamlett replied, "Oh, Ms. McGuinness, we're going to get you back to work real soon."

I introduced myself to Mr. Hamlett. I told him that I worked in the building and was not told that the 7th floor was restricted. We asked Mr. Hamlett to accept the appeal and he took it. When Ms. McGuinness asked him to sign a receipt, he did, I was shocked to learn that the man shouting at us was the OWCP Regional Director.

Two days later, September 18, 1996, Mr. Hamlett called me at my office to hold a conference call with Ms. McGuinness. Mr. Hamlett told us that Jonathan Lawrence, District Director, Kevin Kates, senior claims examiner, and another claims examiner were on the call with him. However, only Mr. Hamlett spoke during the conversation. Mr. Hamlett angrily stated that his staff was presently engaged in responding to Congressman Ackerman and others concerning Diane McGuinness. He accused Ms. McGuinness of calling all over the country. Mr. Hamlett said he had heard from his head office about her calls.

Ms. McGuinness asked him if she could see her file and Mr. Hamlett responded that he would furnish her the part of the file she does not have already via mail. However, Mr. Hamlett said she would not be permitted to visit the office to review her file by going to room 740. Mr. Hamlett said that Ms. McGuinness would be referred to a referee for a decision on her disability. He said he came to his decision without the use of the appeal Ms. McGuinness had presented to him September 16. He said that Ms. McGuinness' appeal was not right.

Ms. McGuinness asked him about her physical therapy being disallowed, and Mr. Hamlett said he made the decision based on medical evidence. I asked him to continue the physical therapy at least

until OWCP makes a decision on her pending disability and he said no. I did not understand his reasoning to stop the physical therapy prior to the decision of the referee. Even the second opinion doctors had recommended that she be provided with physical therapy for at least 12 weeks.

Mr. Hamlett replied that she was injured too long ago to benefit from physical therapy. It was only effective early in the injury, he contended. I said that his decision was inconsistent with the medical evidence and that the physical therapy should be supported until there is a decision on the disability. Mr. Hamlett said no.

Ms. McGuinness asked if she could participate in the selection process of the referee. Mr. Hamlett said he selected the referee and that Ms. McGuinness can have no participation in the selection process. Ms. McGuinness protested stating that regulations permit her to participate in the selection process. Mr. Hamlett said, no, they don't.

Mr. Hamlett stated that he had alerted the building management that anyone found on the 7th floor without an appointment with his office would be escorted out of the building.

During the entire conversation, Mr. Hamlett spoke in an angry and loud tone of voice. Ms. McGuinness asked him not to shout. Mr. Hamlett maintained his angry and loud tone throughout our conversation.

Mr. Hamlett concluded the call by stating that he would send Ms. McGuinness her file from June 21, 1996, to the present, that is the part of the file she did not already have.

I also want to make a comment on two other issues that are serious drawbacks in dealing with the OWCP for employees I have represented. The first is that it takes too long to receive payment after filing a claim after having submitted complete and necessary medical evidence.

The earliest case which I have handled as representative was paid in about 3 months. But the norm for the cases I have handled is at least 6 months or even much longer. Employees encounter severe hardship waiting to be placed in payment status. Often there are delays because the wrong forms or obsolete forms were completed or because employees were not given the correct forms in the first place by their agency.

For example, I have had many problems with the Social Security Administration personnel office who take an inordinate amount of time to process and to send the employee's workers' compensation claim to OWCP.

The second issue which I mentioned earlier is the inability to reach anyone at OWCP. The voice mail system is frustrating and often does not work. More often than not there is no call back after leaving a message. There is insufficient staff to process the workload, and employees seem to have become numb by the backlog of cases they are not able to get to.

I strongly recommend that you support funding the agency for more personnel to improve customer service and to clear the backlog of cases.

I just want to mention the status of three cases that I am currently handling. Case A is an employee with carpal tunnel syndrome injury. He filed a claim for his injury, and it was approved.

He later returned to work and asked for some accommodation so that he could perform the job without incurring injury.

Social Security Administration denied him the requested accommodation. He had to stop working again due to the pain of the carpal tunnel and tendonitis injuries. He filed for compensation November 17, 1998. He has submitted all required medical evidence, but he is still awaiting approval of his claim and payment.

Case B is an employee who had stress-related injury, and she left work in September 1997. She returned to work in June 1998 and continues to work on the job. Her claim was approved by OWCP, but she still is awaiting payment for that period.

Case C is an employee who was receiving compensation for an injury she received in a fall while working. OWCP pressured her to return to work 1 day a week. She did so, but, due to pain, was unable to show up for the 1-day a week on most occasions. She again filed for full compensation and OWCP not only denied that, they decided to deny her entire compensation. Because the employee could not return to work, she filed for disability retirement under Office of Personnel Management.

I represented her before the Merit Systems Protection Board and it was settled with her claim approved. We appealed her denial to workers' compensation and was recently reversed on appeal and awarded retroactively. This award covers the part-time claim, not the full-time claim she filed. She is still awaiting a payment. She continues to receive disability retirement benefits while awaiting workers' compensation.

Mr. HORN. That's very helpful and we're going to pursue some of the questions you've raised with the administration when they testify. Thank you for bringing those points out.

[The prepared statement of Mr. Riordan follows:]

**Statement of John Riordan
before the
Committee on Government Reform's
Subcommittee on Government Management,
Information and Technology**

May 18, 1999

Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to address the topic of Customer Service at the Office of Workers' Compensation Programs by the Department of Labor.

My name is John Riordan. I am First Vice President of the American Federation of Government Employees, AFL-CIO, Council 220 which represents approximately 25,000 Social Security Administration employees in field offices throughout the country. I have been employed by the Social Security Administration for over 25 years and as a union representative, I have represented many SSA employees who have been injured on the job and who have applied for workers' compensation. I am currently representing four employees. None of these employees are receiving compensation benefits at present although they applied for benefits many months ago. I encounter difficulties contacting agents because of the voice mail system. You are no longer able to speak with an agent. Instead, I have to leave voice recorded messages. When I receive no response, I have to write to them even though I work in the same building (201 Varick St., New York City) where they are located. They imposed a strict policy restricting visitors to their offices a couple of years ago. I want to recount briefly an incident which occurred on Sept. 16, 1998 when I accompanied a customer who wanted to deliver some documents to OWCP office at 201 Varick St. The customer who I accompanied is Dianne McGuinness who testified earlier before the Subcommittee.

Ms. Dianne McGuinness came to my office and we reviewed some of the documents she wanted to submit to OWCP. Ms. McGuinness wanted to deliver her appeal of the denial of the continuation of her Workers' Compensation. I was at that time President of AFGE Local 3369 which represents SSA FO employees in New York City, Long Island and Westchester County. We took the elevator from the 11th Floor to the 7th Floor where OWCP is located. The door to the office was locked and there was no mail slot. While searching for a place to

deliver the appeal, a man appeared at the end of the long corridor and started shouting. I tried to ignore him but Ms. McGuinness said to me that he was shouting at us. As the man approached he was still shouting and indeed it was directed towards us. We attempted to explain to him why we were there but he didn't stop talking to us so he could hear our response. He told us to leave the building immediately. He said we had to have an appointment to be there. I told him that I had called to make an appointment earlier but no one responded to our calls. Ms. McGuinness and I told him that we were federal employees. The man responded that he didn't care whether or not we were federal employees and that he would call the security guards to remove us if we did not leave. Ms. McGuinness had made an appointment through the Senator's office to deliver the appeal, but she was not allowed to tell the man this because he would not let her talk. The man was visibly upset and disturbed by our presence. Ms. McGuinness asked him if he was Mr. Kenneth Hamlett (the NY Regional Director OWCP) and he said he was. Ms. McGuinness introduced herself to him and Mr. Hamlett replied, "Oh, Ms. McGuinness, we're going to get you back to work real soon." I introduced myself to Mr. Hamlett. I told him that I worked in the building and was not told that the 7th Floor was restricted. We asked Mr. Hamlett to accept the appeal and he took it. But Ms. McGuinness asked him to sign a receipt. He did. I was shocked to learn that the man shouting at us was the OWCP Regional Director.

Two days later, Sept. 18, 1998, Mr. Hamlett called me in my office to hold a conference call with Ms. McGuinness. Mr. Hamlett told us that Jonathan Lawrence, District Director, and Kevin Kates, Senior Claims Examiner and another claims examiner were on the call with him. However, only Mr. Hamlett spoke during the conversation. Mr. Hamlett angrily stated that his staff was presently engaged in responding to Congressman Ackerman and others concerning Dianne McGuinness. He accused Ms. McGuinness of calling all over the country. Mr. Hamlett said he had heard from his head office about her calls. Ms. McGuinness asked him if she could see her file and Mr. Hamlett responded that he would furnish her the part of the file she does not already have via mail. However, Mr. Hamlett said she would not be permitted to visit the office to review her file by going to Room 740. Mr. Hamlett said that Ms. McGuinness would be referred to a referee for a decision on her disability. He said he made his decision without the use of the appeal Ms McGuinness had presented to him Sept. 16. He said that Ms McGuinness's appeal was not ripe.

Ms McGuinness asked him about her physical therapy being disallowed and Mr. Hamlett said he made the decision based on medical evidence. I asked him to

continue the physical therapy at least until OWCP makes a decision on her pending disability and he said no. I did not understand his reasoning to stop the physical therapy prior to the decision of the referee. Even the second-opinion doctors had recommended that she be provided with physical therapy for at least 12 weeks. Mr. Hamlett replied that she was injured too long ago to benefit from physical therapy. It was only effective early in the injury, he contended. I said that his decision was inconsistent with the medical evidence and that physical therapy should be supported until there is a decision on the disability. Mr. Hamlett said no.

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During the entire conversation, Mr. Hamlett spoke in an angry and loud tone of voice. Ms. McGuinness asked him not to shout. Mr. Hamlett maintained his angry and loud tone throughout our conversation. Mr. Hamlett concluded the call by stating that he would send Ms McGuinness her file from June 21, 1996 to the present, i.e., the part of the file she did not already have.

I also want to comment on two other issues that are serious drawbacks in dealing with OWCP for employees I have represented. The first is that it takes too long to receive payment after filing a claim after having submitted complete and necessary medical evidence. The earliest case which I have handled as representative was paid in about three months. But the norm for the most cases I have handled is at least six months or even much longer. Employees encounter severe hardship waiting to be placed in payment status.

Often there are delays because the wrong forms or obsolete forms were completed or because employees were not given the correct forms in the first place by their agency. For example, I have had many problems with the SSA personnel office who take an inordinate amount of time to process and to send the employee's workers' compensation claim to OWCP. The second issue, which I mentioned earlier, is the inability to reach anyone at OWCP. The voice mail system is frustrating and often does not work right. More often than not, there is no call back after leaving a message. There is insufficient staff to process the

workload and employees seem to have become numbed by the backlog of cases they are not able to get to. I strongly recommend that you support funding the agency for more personnel to improve customer service and to clear the backlog of cases.

Status of three of the cases I am currently handling.

Case A is an employee with a carpal tunnel syndrome injury. He filed a claim for his injury and it was approved. He later returned to work and asked for some accommodations so he could perform the job without incurring injury. SSA denied him the requested accommodation. He had to stop working again due to the pain of his carpal tunnel and tendonitis injuries. He filed for compensation 11/17/98. He has submitted all required medical evidence, but he is still awaiting approval of his claim and payment.

Case B is an employee who had a stress-related injury and she left work in Sept. '97. She returned to work June '98 and continues to work on the job. Her claim was approved by OWCP, but she is still waiting for payment.

Case C is an employee who was receiving compensation for an injury she received in a fall while working. OWCP pressured her to return to work one day a week. She did so but due to pain was unable to show up for the one day a week on most occasions. She again filed for full compensation and OWCP not only denied that, they decided to deny her entire compensation. Because the employee could not return to work, she filed for disability retirement under OPM. I represented her before the MSPB and it was settled with her claim approved. We appealed her denial of Worker's Compensation, and it was recently reversed on appeal and awarded retroactively. This award covers the part-time claim not the full-time claim she filed. She is awaiting payment. She continues to receive disability retirement benefits while awaiting Worker's Compensation.

Mr. HORN. James Linehan is an attorney. And please identify where. And proceed with your testimony.

Mr. LINEHAN. Thank you, Mr. Chairman, for the opportunity to be here. My name is James Linehan, Jim Linehan out of Oklahoma City area. I am an attorney, solo practitioner. I represent disabled claimants before FECA, OWCP, Merit Systems Protection Board, Social Security Administration, and Federal courts.

Basically I have submitted a statement. The statement is out there. I'm not going to read through it, but I will break it down for you. I find it rather incredible that in this current city I have never been here before but I understand this to be a city of attorneys. There is 1½ million attorneys in the United States, I know of three or four, including myself, who will be willing to take on these claims, these OWCP claims. I find it incredible that out of all of this city you have to find an attorney in Oklahoma to come up and speak on these claims. I think that speaks loudly for itself.

I also find it not unusual with the testimony that's just been entered about the medical treatment status. Presently in Oklahoma, I know of only one to three neurosurgeons, orthopedic surgeons, et cetera, who will treat or take on Federal workers' compensation cases. That's a couple of weeks ago. I do not think they will take them on anymore.

That leaves no physicians I know of in the State of Oklahoma who will take on these claims. I know of no attorney in the State of Oklahoma beside myself who will represent these claims. The reason why, other than these are bureaucratic nightmares, I have broken down further. There's two general issues. In my opinion, the main issue is nonaccountability. The OWCP, in my opinion, is a self-regulating, self-governing agency that answers by law to no court of law. It has, thus, no incentive to answer to anyone. It has no incentive to handle these cases in the claimant's best interest.

I have broken this down in the statement, but in general the nonaccountability of Fed Comp OWCP is what leads to no attorney representation. Essentially there's nothing for an attorney to do. And how do I handle claims? Basically—and attorneys tell me never to tell this, but I tell it all the time any way—people pay me money to tell a government bureaucrat to do what they're supposed to do in the first place. That's what it boils down to.

As a result of nonaccountability, there's a distinct lack of medical treatment. In my opinion, as a result of this nonaccountability and its effect on medical treatment there's millions upon millions of dollars being diverted from OWCP to private sector insurers to cover them.

How does this work? In a typical back case that I see, \$150,000 is spent for operative physical therapy because of the bureaucratic nightmare the claimants and doctors have to go through. They have to wait months on end to get medical treatment authorized, yet the claimant needs the surgery now. Their doctor says they cannot wait months. The claimant and I need something. There is no response from OWCP.

Very easy. The claimant and doctor turn it over to private insurance. Private insurance carries it. They never know it's Fed Comp. I see this 20, 30, 40, 50 times a year. Multiply it out, \$100,000 per claim, it's very easy math. This is in Oklahoma alone.

I get calls from Hawaii to New York to Florida to Alaska to handle these claims. I see this constantly. Can I prove how much money is being diverted? No. You would have to go to the medical establishment. I just say this is what I see.

The nonaccountability of the OWCP basically results from the fact that it answers to no court of law. What does this mean? This means the OWCP—and I'm always referring to OWCP—can knowingly and freely act in any manner it wants to with the claimants. This is what you're hearing testimony before about. This is what you're hearing testimony today about. There is no incentive for the OWCP to respond to a claimant. There is nothing the claimant can do in response. The OWCP can act as it wants.

In the typical OWCP claim, the claimant is under guidelines to respond, submit forms this, forms that, within 30 days, 10 days here, et cetera, if you don't, Mr. Claimant, your job will be terminated. You will lose benefits, et cetera.

These are real life happenings. They lose benefits, they lose their home, they lose their car, they can't feed kids. In return, the OWCP is under absolutely no guidelines whatsoever to respond in any timely manner. The claimant has to respond. The OWCP never has to respond. That's why you see comment after comment, no return phone calls, no response to filings, et cetera.

The other thing in addition to nonaccountability I have outlined is unilateral control. As a result of unilateral control that the OWCP has over these claims, I gave two examples. One is the attending physician rule. Federal courts across this country, the Social Security Administration, et cetera, all recognize the attending physician rule.

I have put it in my statement. Basically, what this means is that the claimant's qualified medical attending physician prevails over the reports of a hired, paid consultant of the agency. Speaks common sense. The qualified medical practitioner for the claimant knows him, has treated him for years, et cetera.

The agency is a paid doctor, may not ever examine the claimant, may only look briefly at reports, if at all, or may examine the claimant, from what I see and as testimony this morning reflected, 5 to 10 minutes. That's normal.

In OWCP land, the attending physician rule is the exact opposite. If there's a contest between medical reports, the paid non-examining, barely examining report of the OWCP doctor prevails over the attending physician. Thus another incentive for medical practitioners not to take these claims. They can't get treatment authorized. They are subversive to whoever OWCP can shop around and find, \$250 to pay for a report to say what they want. This is how it works in real life. I see this daily.

The other example of unilateral control that I see—and this is a killer clause I call it, Section 8128(a)(1) of the OWCP. This is a simple clause and it's a quite deadly clause for Federal employees. This basically means that the Secretary of Labor—under this clause if a Federal employee can succeed in gaining benefits on his or her claim, can gain a scheduled award, whatever she or he gets, under Section 8128 the killer clause, the Secretary of Labor or his or her designee, anybody down the road, down to the claims examiner level, can on own motion, without notice, without hearing,

anything, simply take the award, take the benefits back, demand repayment. There is no time limit on this. There is—it's—I just simply call it the killer clause.

If a claimant is successful, if they didn't tick the OWCP off enough, they may get to keep their claim. However, in they're successful, and they tick the OWCP off, and 8128 can come back in and say simply hand the money back. That's it. There is no right of review.

As a result of this what I see daily in these claims, I have one recommendation that will solve a lot of problems. These are not second-class citizens. This Congress looked at VA claims back in 1998. It was the same setup. VA acted unilaterally without control over veterans benefits for years. Couldn't get attorney representation. I think the old law was \$25 for an attorney.

In 1988, this Congress came in and said enough of this. Veterans needs to be recognized as full citizens with full rights. They created the Court of Veterans Appeals. Veterans now get the right to have Federal court review their claims. They have attorneys now.

The lower administration, the Veterans Administration can no longer deny claims randomly, can no longer deny due process. They have to give hearings. They have to provide reports in a timely manner. They have to act according to Federal court rules.

This is what needs to be done for the OWCP. These people are not second-class citizens. They need the right, they deserve the right to have Federal court review.

Whether or not they should have their own Federal court, I leave this up to Congress. I know you're going to get into the budget, et cetera, I'm not concerned with that. My concern is only that somehow there be Federal court review. We could use the present system.

You don't need the ECAB system anymore. If you're saving money, take it away. It's a useless appeal. It goes nowhere. They can have their administrative hearing at the lower level, file the claim, the administrative hearing, much as in Social Security, if it's denied there, file a claim in Federal court. It's very simple.

If the Federal court then sees that the OWCP is not following due process rules regarding notice, production of documents, everything else you hear constantly in these claims, it's very simple: Sanctions. A Federal court will start stomping on the toes that need to be stomped on. That's what it boils down to. Until then, in my frank opinion, nothing will change. This will go on. That is my recommendation.

I'm open for questions at any time.

Mr. HORN. I never thought I would hear a lawyer's statement that I agreed with, so I'm glad you came, because you're the exception to my rule. I mean, that's a brilliant statement and I really appreciate it.

Mr. LINEHAN. Thank you.

[The prepared statement of Mr. Linehan follows:]

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June 1, 1999

Congress of the United States
 Honorable Stephen Horn, Chairman
 Subcommittee on Government Management,
 Information, and Technology
 Rayburn House Office Building, Room B-373
 Washington D.C. 20515-6143

RE: OVERSIGHT OF CUSTOMER SERVICE AT THE OWCP

Honorable Chairman:

Pursuant to your invitation of May 5th, 1999, the following statement is respectfully submitted as a synopsis of expected testimony to be presented via appearance of the undersigned witness. Said voluntary appearance has been requested before this Subcommittee on Tuesday, May 18th, 1999 at 10:00 a.m.

GENERAL

A. Expected Purpose

The expected purpose of this Subcommittee hearing is to gather information on the processes, methods, and workings of the United States Department of Labor Office of Workers' Compensation Programs ("OWCP"). The response of the OWCP to claims by federal civilian employees or their survivors who are or have been injured, diseased or killed on the job in and out of the course of their federal employment will be the specific subject of inquiry. In addition to federal employee testimony, additional testimony is expected from "professionals"; e.g. medical and legal personnel who are involved in the claims processes of OWCP on behalf of federal civilian employees.

B. The OWCP

Federal employees who are injured, diseased or killed on the job as a federal employee are required to apply to the OWCP in the Department of Labor for workers' compensation benefits. Statutory authority is contained in Title 5 U.S.C. §8103 et. seq. The OWCP is a self-governed, self-regulating, exclusive rights agency. The unilateral responses and actions of the OWCP in claims decisions are final and conclusive for all purposes with respect to all questions of law and fact and are not subject to review by another official of the United States or by a court by mandamus or otherwise. 5 U.S.C. §8128(b).

Thus for all practical effect and purpose, for those federal civilian employees injured, diseased or killed on the job, their exclusive remedy for relief is to resort to the OWCP system with *no rights of appeal to any court of law in the United States.*

C. The Claimant

There are, to the undersigned's estimation, between 2.5 and 3 million federal civilian employees in

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 OF APPEALS FOR THE TENTH CIRCUIT • UNITED STATES COURT OF VETERAN APPEALS

the United States. Federal employees covered under the OWCP include a range of employees such as postal workers, Peace Corps and Volunteers of America workers, student-employees. Generally, any officer or employee of any branch of the government or any individual rendering personal service to the United States falls within the parameters of OWCP. 5 U.S.C §8101 et seq.

D. Legal Representation

There are, to the undersigned's current estimation, more than 1 million practicing attorneys in the United States. Presently, the undersigned, knows of only three (3) to four (4) other attorneys in the entire United States willing to represent federal civilian employees in OWCP claims. The undersigned knows of no (0) other attorneys in his State of Oklahoma who will represent federal civilian employees in these claims.

E. Medical Treatment

Presently, the undersigned knows of only one (1) to three (3) qualified medical physicians in the State of Oklahoma who are willing to medical treat federal civilian employees who are proceeding with a federal workers' compensation claim under the OWCP. The undersigned is not aware of the status of medical treatment availability for the remainder of the United States. However, based on weekly telephone calls received from federal civilian employees across the United States, the rarity or non-existence of medical providers for injured federal employees is common.

SPECIFIC PROBLEM AREAS

A. Nonaccountability

If there can be described one overall riding concern common to the OWCP claims handling process, the concern would be the express total nonaccountability of the OWCP to any overseer. As noted above, the OWCP is essentially, and for all practical purposes a self-governing, self-regulating federal agency that answers to no court of law. This nonaccountability of a federal agency leads to an obvious and common sense concept: a federal agency that is not required to answer or account for its actions need not concern itself with its action (or lack of action).

Specifically and most practically, why should the OWCP concern itself with its responses and decisions on federal workers' compensation claims? There is nothing "legally" that the injured federal employee can do in response to the OWCP. There is no incentive, legally or economically, for the OWCP to act in the "best interest" of the federal employee. In reality, quite the opposite occurs. The OWCP can freely act to delay, stall or deny claims as desired. A federal employee meeting such delays in the face of mounting bills will grow increasingly frustrated with the OWCP claims process. The federal employee will either forego further action on her claim or will drop or refuse to file her claim. Thus, it is in the "best interest" of the OWCP to delay, stall or deny claims as such *non-action* saves the OWCP from claims payments. The OWCP will not have to pay out compensation benefits to a now thoroughly disgusted federal employee. Additionally, the never filed injury claim allows the federal employer to claim that the federal employer's workplace injury rate is artificially lower since fewer claims are filed. Both the OWCP and federal employer gain whereas the employee and her family continually lose.

Effects of Nonaccountability of OWCP on the Medical Treatment of Federal Workers

The effect of nonaccountability of the OWCP in its claims handling and decisions directly leads to the rapidly growing refusal of qualified medical practitioners across the United States to medically treat injured or diseased federal civilian employees. The nonaccountability of the OWCP, also leads to the diversion of due payment of millions of dollars per year in compensation benefits to the private sector.

Annually, millions of dollars of benefits actually due as federal compensation are, in the undersigned's opinion, being wrongfully diverted to private insurers for payment as result of OWCP's nonaccountability. For example: an on the job back injury resulting in a herniated disc followed by surgery and physical therapy will average more than \$150,000.00 in immediate medical costs. These medical costs are due and payable by the OWCP. However, with nonaccountability, the OWCP can simply, and knowingly, stall and delay authorization of medical treatment on the workers compensation claim for months on end. *(The OWCP is under no statutory guideline or regulation requiring its timely response - - or any response for that matter - - to any federal employee's workers' compensation claim. The OWCP mandates that it must pre-approve and authorize medical treatment, however, the OWCP is under no timeline requiring it to issue such approval and authorization for medical treatment.)* The injured federal worker who needs immediate medical treatment must first find a physician who will treat her. The physician is highly reluctant to even accept the case as the physician is well aware that she may not be paid for months, or years, if at all, by the OWCP. But, needing medical treatment, and needing to be paid for medical services, both the employee and the physician avoid OWCP and its indeterminable delays. The federal employee and her physician simply file her claim and medical bills with the employee's private insurer. The private insurer, in turn, unknowingly pays for medical services that are in reality the total responsibility of OWCP. Thus, with nonaccountability, the OWCP has every incentive *not to act* in the best interest of the injured employee. By *not taking action* through nonaccountability the OWCP can, and does, divert millions of dollars per year onto the backs (literally) of the private sector. In turn, the OWCP and federal employer can claim artificially reduced injury rates, reduced compensation claims paid, etc. In reality, the private insurers and American citizens are bearing the increased burden of nonaccountability: private insurance premium rates continue to rise to cover the nonaction of the OWCP.

Nonaccountability of the OWCP also leads directly to increasing refusals of federal employees to either initially file their claim or to later prematurely drop their workers' compensation claims. It is in the best interest of the OWCP *not to take action* on the employee's claim. By not acting on a claim, OWCP avoids payment of compensation benefits to the employee if the employee never files or when the employee subsequently drops his claim. No claim means no payment. A very simple means of denial of benefits payments by OWCP.

Nonaccountability of the OWCP also leads directly to increasing refusals of medical practitioners to treat injured or diseased federal employees. It is in the best interest of the OWCP *not to authorize medical treatment*. By not acting on a request for medical treatment authorization, OWCP avoids payment of medical treatment costs to the physician and the physician subsequently bills the private insurer. No authorization means no payment. Again, a very simple means of denial of benefits payments by OWCP.

Effects of Nonaccountability on Legal Representation of Federal Workers

As stated above, there are less than a handful of practicing attorneys across the United States who will represent federal civilian employees in their workers' compensation claims. The reason for this rarity of legal representation is quite simple: the express nonaccountability of the OWCP, its actions or nonactions, to *any* court review provides no legal peg on which an attorney can hang his hat in support of the federal employee. No review means no payment. Again, a very simple means of denial of benefits payments by OWCP.

With no accountability to any court of law, the OWCP *knowingly* is free to act in any manner it so desires toward an injured federal civilian employee. The OWCP *knowingly* is free to refuse to respond to claimant's telephone calls; to *knowingly* refuse to acknowledge receipt of correspondence, medical records, etc. from the claimant or her physician; to *knowingly* delay or *knowingly and wrongfully* deny due compensation benefits to the claimant; to *knowingly* refuse to provide OWCP file records upon request to the claimant; etc.

The OWCP's express nonaccountability to *any* court of law for its actions and nonactions on a federal workers' compensation claim leads to a most common sense observation. *The OWCP is free to do what it wants, when it wants, how it wants and why it wants on any federal workers' compensation claim.* Frankly, the undersigned knows of no other better example of the "fox left guarding the henhouse."

B. Unilateral Control

As can be seen, allowed nonaccountability, the OWCP can, and does, assert full and final unilateral control over the claimant and all issues involving a claim for workers' compensation benefits. 5 U.S.C. §8128(b). This issue of unilateral control can be readily illustrated by the following two examples.

The Attending Physician Rule

Under most circumstances in courts of law or otherwise, the attending physician rule prevails. This rule is quite simple. In a contest between the injured claimant's qualified attending medical physician and an agency's non-attending consultative examiner regarding medical treatment, the qualified medical recommendations and reports of the attending physician prevail and take precedence over the paid consultant. The United States Federal Court of Appeals and the United States Social Security Administration recognize that "The 'Attending Physicians Rule' was developed because such an opinion 'reflects an expert judgment based on a continuing observation of the patient's condition over a prolonged period of time.' " *Foster v. Heckler*, 780 F.2d 1125, 1130 (4th Cir.1986) (quoting > *Mitchell v. Schweiker*, 699 F.2d 185, 187 (4th Cir.1983)).

The exact opposite holds true in OWCP claims. 5 U.S.C. §8123 states that when there is a conflict in medical evidence of equal weight, the opinion of the hired medical consultant of the OWCP prevails over that of the claimant's attending physician. The detailed medical treatment reports of a federal employee's attending physician are considered less qualified than the medical report of a non-examining physician retained and paid by OWCP. This occurs despite the fact that the employee's attending physician's expert judgment reflects the continuing observation of the patient's condition over a prolonged period of time. With total unilateral control by the OWCP over the medical treatment of the federal employee, it is in the *best interest of OWCP* *not* to recognize the attending physician rule. The OWCP, with unilateral control over its choice of the prevailing medical report needs only to "shop around" for a paid consultant to state any medical diagnosis the OWCP so desires. With such unilateral control over the claimant's own attending physician, the OWCP has *no incentive* to act in the best interest of the federal employee.

Section 8128(a)(1)

This section of OWCP regulations is quite simple and quite deadly for federal employees. This small and often unnoticed clause permits the Secretary of Labor (or any designate) to review *for any reason - at any time - any claim - for federal workers' compensation.*

Section 8128 allows the OWCP to unilaterally end, decrease or increase any award of compensation benefits paid to the claimant.

No pre-notice of such loss of compensation is required to be given to the claimant.

No due process hearing on such loss of compensation is required to be given to the claimant.

Subsequently, as explained above, Section 8128(b) then states that such a unilateral review of an award and its results is not reviewable in any court of law and is final.

In quite simple terms, this clause is the *trump card* of all cards for OWCP. In the event a claimant should ever prevail on her federal workers' compensation claim, the award given can always be taken back by the OWCP. Regardless of when the claimant was awarded benefits (there is no time limiting review by the OWCP); regardless of appropriateness of the claimant's award; regardless of the claimant's; the OWCP can *and will* at any time, now or in the distant future, on its own motion, *without any right of review, end or decrease the claimant's compensation benefits.*

Without any pre-notice and without any right of hearing, a federal employee's previously awarded compensation benefits can be taken back by OWCP and demand for reimbursement made upon the employee at any time by the OWCP.

The Sword of Damocles never hung so precariously over a head as does Section 8128(a)(1) hang over the head of an injured or diseased federal employee and her family. Should she fight so hard to eventually win her due benefits, and thus be finally able to feed and house her family again, at any time -- now or in the distant future -- without warning and with no chance to avoid, the sword of Section 8128(a)(1) can and will slash down with a fury upon the federal employee and her family.

Section 8128(a)(1) is a prime example of unilateral regulatory control risen to an ultimate and final extreme without regard to its effect on federal employees.

RECOMMENDATION

The present federal workers' compensation under OWCP is a federal system without accountability to any court of law; a federal system that costs the private insurance sector millions of dollars annually; and a federal system of unilateral control with no incentive to assure that the effects of its actions are in the best interest of the federal employee. The OWCP is essentially a federal agency that has and continues to answer to no one.

The Veteran's Administration was a similarly situated federal system. For decades the VA remained unaccountable for its actions and was the curse of veterans seeking disability compensation for their service connected injuries. For decades, veterans were left without legal representation in their claims for disability. In 1988, this Congress recognized that after decades of nonaccountability of the VA to veterans and after years of virtual unilateral control by the VA over veterans disability claims, veterans' law and regulations needed a vast but simple and effective overhaul. This Congress properly decided that the laws for veteran's seeking compensation for their service connected disability claims should be changed to the serve the *best interest of the veterans* rather the best interest of the VA. In 1988, this Congress enacted legislation creating a federal court system of review for veteran's disability claims. VA disability claims, after VA administrative review, were made subject to federal court appellate review. The VA now affords veterans' due process in the processing of their claims. Veterans are permitted to seek and retain legal representation with fees for same to be reimbursed by the VA should the veteran be the prevailing party on her claim. Veterans can rest assured that if their claims are wrongly decided at the administrative level, they will be at least be granted right of federal court review. Faced with such federal court review, the VA must necessarily act promptly and in the best interest of the veteran in the handling and processing of veterans' disability claims.

The undersigned recommends that this Congress also act in the best interest of the thousands of injured, diseased or killed federal employees seeking federal workers' compensation for themselves and their families. The undersigned recommends that the most simple and effective means of insuring that the OWCP acts in the best interest of the federal employee (rather than the OWCP) is to allow the federal employee a basic right of federal court review of her federal workers' compensation claim. With the prospect of federal court review overseeing its actions (or nonaction), the OWCP will have every incentive to act in the best interest of the injured federal employee rather than the best interest of OWCP. Federal court review of OWCP claims will require that the OWCP respond in a pre-set timely

June 1, 1999

manner to federal employee's request for information and action on their claim. Federal court review will insure that the OWCP responds in pre-set timely manner to federal employee's and their physicians request for authorization of necessary medical treatment. Federal court review will insure that medical costs being presently diverted to private insurers for payment are correctly processed and accounted for by OWCP in a timely manner thus assuring the federal employee of the availability of medical treatment. Federal court review of OWCP claims will also assure that claimant that in case of appeal she will have greater opportunity to be represented by legal counsel.

In summary, by simply allowing federal civilian employees to appeal their OWCP claims to a federal court of review; the above noted problems of nonaccountability and unilateral control of the OWCP disappear. Without such court oversight, federal employees seeking compensation for their on the job injuries remain subject to the whims and will of an essentially nonregulated agency.

Sincerely,



James R. Linehan P.C.

Attorney at Law

Mr. HORN. Our last one on this panel is Tina Maggio, and she is the field representative for a respected Member of this body, Representative Michael F. Doyle.

Ms. MAGGIO. Thank you Chairman Hornman—Horn. Sorry. I'm nervous. Thank you, Chairman Horn for allowing me this opportunity.

I have been working for Representative Mike Doyle's district office as field representative for 3 years. As part of my responsibilities, I assist constituents with problems with OWCP as well as the Social Security Administration, the U.S. Postal Service, Medicare, and the Office of Personnel Management.

For OWCP cases, a majority of my contact is with the Philadelphia District Office. In looking over the history of my case work, I have handled approximately 30 to 35 cases.

Since each individual case is different and varies in complexity, I do not believe it would be fair for me to make a generalized statement regarding the responsiveness of OWCP to congressional calls or correspondence.

Therefore, I would like to discuss my constituent casework in which I deal with the Philadelphia District Office. In my written statement, I outline three case examples in detail which provide a broader understanding of my correspondence with the OWCP.

The first example is—I first spoke with this individual on March 8, 1999. He has an approved medical claim through OWCP and has been waiting for a prescription reimbursement since May 1998. He was referred to seek assistance from Representative Doyle by his injury compensation specialist at the Postal Service because neither she, the drugstore, nor this constituent could get a response from the claims examiner.

The constituent told me that he was reducing the amount of his medication because he could no longer afford to pay for the prescription without getting reimbursed. On March 8, 10, and 16, I contacted the Philadelphia District Office and left a message for his claims examiner. On March 17, I faxed a letter to the District Director's office regarding this matter. On March 25, I called the Philadelphia District Office and spoke with the assistant in the District Director's office. I told her that I had left numerous messages for the claims examiner to call me back, but I had not yet heard from him. She told me that all congressional calls are supposed to be answered within 1 day.

She put me through to the supervisory claims examiner's voice mail, and I left a message.

On March 26, I called and left another message for both the claims examiner and the supervisory claims examiner. On March 29, I finally received a call from the constituent's claims examiner. This was 3 weeks from when I had initially contacted OWCP.

At this point, I asked him if he had received any of my messages. He told me the only message he received was from the supervisory claims examiner to give me a call back. Once the claims examiner did call me back, he explained what this individual needed to do to resolve his prescription reimbursement problem and everything was taken care of.

The next case I would like to discuss is outlined in my written statement pertaining to the determination of benefits.

I would like to submit the following pertinent documentation for the record: First, a letter that the individual received from the District Director dated October 29, 1998, in which the District Director states that all phone and written inquiries received from Congressman Doyle's office are promptly answered.

[The information referred to follows:]

U.S. DEPARTMENT OF LABOR

Employment Standards Administration
Office of Workers' Compensation
3535 Market Street, Rm. 15100
Philadelphia, Pennsylvania 19104



October 29, 1998

Charles T. Blystone
1101 Preston Drive
N. Versailles, PA 15137

Dear Mr. Blystone:

I am writing in response to your letter dated October 14, 1998 to Mr. T. Michael Kerr, Deputy Assistant Secretary for the Office of Workers' Compensation Programs, Washington, D.C. You had contacted Mr. Kerr for assistance with Case #A6-509895. He has referred your correspondence to my attention for reply.

As you've mentioned, you've requested a hearing by the Branch of Hearings and Review on the denial decision rendered in Case A6-509895. Your casefile was transferred by the Philadelphia District Office to the Branch of Hearings and Review on October 8, 1998. That appellate body now has temporary jurisdiction over this case until a decision is rendered by the Hearing Representative.

In your October 14, 1998 letter, you cite the non-responsiveness of the Philadelphia District Office to Congressman Doyle's phonecalls and letters regarding your case. Records indicate that the following responses were, in fact, made to Congressman Doyle's inquiries:

Phonecalls

June 24, 1998, Phone contact between Supervisory Claims Examiner, Ann Bazik, and Congressional Aide, Tina Maggio

June 26, 1998, Phone contact between Supervisory Claims Examiner, Ann Bazik, and Congressional Aide, Tina Maggio

August 3, 1998, Phone contact between Senior Claims Examiner, Toby Rubenstein, and Congressional Aide, Tina Maggio

October 1, 1998, Phone contact between District Director, William Staarman, and Congressional Aide, Tina Maggio

Written Responses

August 19, 1998, Written reply to Congressman Doyle's Office by District Director, William Staarman

September 24, 1998, Written reply to Congressman Doyle's Office by District Director, William Staarman

I can assure you that ALL phone and written inquiries received from Congressman Doyle's Office have been promptly answered by the Philadelphia District Office. Note, too, that the September 10, 1998 inquiry from Congressman Doyle's Office, which you included with your October 14, 1998 letter to Mr. Kerr, was responded to by the Philadelphia District Office on September 24, 1998.

In addition to keeping Congressman Doyle's Office fully apprised as to the status of your case, the Philadelphia District Office also responded to your own phone and written inquiries, as follows:

Phonecalls

June 15, 1998, Phone contact between Claims Examiner, Claudia Harris, and yourself

June 23, 1998, Phone contact between Supervisory Claims Examiner, Ann Bazik, and yourself

September 22, 1998, Phone contact between Supervisory Claims Examiner, Ann Bazik, and yourself

Written Responses

July 22, 1998, Written reply to your inquiry by the Regional Director, R. David Lotz


Attached to your letter to Mr. Kerr was a copy of a letter, dated October 13, 1998, from you to R. David Lotz, Regional Director, in Phila., PA. Please note, as mentioned above, that Case #A6-50989 was physically transferred to the Branch of Hearings and Review in Washington, D.C. on October 8, 1998. That appellate body has now assumed temporary jurisdiction over your case. Therefore, at this point in time, you should address any inquiries regarding Case #A6-509895 to the Branch of Hearings and Review in Washington, D.C., where your case is now located, rather than to the Phila. District Office. Any mail which the Phila. District Office has received on your case since its transfer would have been forwarded to the Branch of Hearings and Review.

It's clear from your October 14, 1998 letter to Mr. Kerr that you disagree with the Philadelphia District Office's unfavorable decision rendered on Case #A6-509895. You have chosen to pursue the matter by requesting a hearing. Any additional factual and/or medical evidence which you may have to support your claim should be addressed to the Branch of Hearings and Review. I can assure you that any such additional evidence submitted will be fully reviewed and considered by the Hearing Representative. This would include any arguments that you may have regarding your claim.

Let me take this opportunity to update you regarding the current status of Case #A3-226839, a case which the Philadelphia District Office is currently handling. An appointment has been scheduled for you to be examined by the Board-Certified Impartial Specialist, Dr. Laing, on November 16, 1998. The purpose of this referee exam is to resolve the conflict in medical opinion within the casefile as to the possible connection between your current right knee problems and the April 21, 1997 work injury. Any decision regarding halogen shots and surgery must await the District Office's receipt and review of Dr. Laing's report following his exam. (These were issues which you'd raised in your October 13, 1998 letter to Mr. Lotz, attached to your letter to Mr. Kerr.)

To summarize: the Philadelphia District Office has been fully responsive to inquiries from both you and Congressman Doyle's Office. Any additional evidence which you may have to support Case #A6-509895, including written arguments, should be addressed to the Branch of Hearings and Review in Washington, D.C. for their consideration, not to the Philadelphia District Office. Regarding Case #A3-226839, a final decision will be rendered after the Impartial Specialist's report is received and reviewed following your November 16, 1998 exam.

Cases are adjudicated and managed in the program's district offices. Therefore, the best source of information about a case is usually the staff of the district office. If you need further case-specific information about Case A3-226839, please write to: U.S. Department of Labor; Office of Workers' Compensation Programs; District Office; Room 15100; 3535 Market Street; Philadelphia, PA 19104. Or, you may telephone the district office at (215) 596-1457. If you need further case-specific information about Case #A6-509895, please write to: Branch of Hearings and Review; P.O. Box 37117; Washington, D.C. 20013. Or, you may call the Branch of Hearings and Review at (202) 219-6155.

Sincerely,

 William J. Staarman
 District Director

Ms. MAGGIO. However, what this letter does not state is the number of phone messages that were left before my phone calls were actually returned, nor does it state that the written responses did not address the issues clearly specified in Representative Doyle's letters.

In addition, I would also like to submit the letter sent to the District Director dated August 4, 1998; the response from the District Director dated August 25, 1998; the letter sent to the District Director dated September 29—or September 9, 1998; and the questions faxed to the District Director on September 29, 1998, after the individual's benefits were terminated.

[The information referred to follows:]

MIKE DOYLE
18TH DISTRICT, PENNSYLVANIA
COMMITTEE ON SCIENCE
SUBCOMMITTEES:
ENERGY AND ENVIRONMENT
TECHNOLOGY

COMMITTEE ON
VETERANS' AFFAIRS
SUBCOMMITTEE:
HEALTH

DEMOCRATIC WHIP,
SOPHOMORE CLASS



Congress of the United States
House of Representatives

August 4, 1998

133 CANNON BUILDING
WASHINGTON, DC 20515
(202) 225-2135

DISTRICT OFFICES:

11 DUFF ROAD
PENN HILLS, PA 15235
(412) 241-6055

541 FIFTH AVENUE
MCKEESPORT, PA 15122
(412) 664-0349

E-MAIL:
rep.doyle@mail.house.gov

WEB SITE:
<http://www.house.gov/doyle>

Mr. William J. Staarman
District Director OWCP
Department of Labor
Gateway Building
Room 15100
Philadelphia, Pennsylvania 19104

Dear Mr. Staarman:

I am writing on behalf of a constituent of mine, Charles T. Blystone, Claim Numbers A6509895 and A3226839, who my office has been assisting regarding his work-related injuries with the United States Postal Service.

Although Mr. Blystone has already submitted his point-by-point appeal of your decision to terminate his benefits on Claim A6509895 and deny his request for a scheduled award, I am writing to reiterate many of the arguments he makes regarding the inaccurate facts stated in the "Memorandum to the Director" by Toby Rubenstein, Claims Examiner.

First, Mr. Blystone clearly makes his arguments regarding the misinformation that both Ms. Rubenstein and Dr. Tauberg state in their decisions and opinions. I have enclosed a copy of Mr. Blystone's appeal for your review. All of the information that Mr. Blystone presents in his argument is supported by the evidence that I have also enclosed.

It is very troubling to me that this case has not been properly processed and resolved. It seems quite evident to me that Mr. Blystone was going through the process of getting a scheduled award by the documentation that was submitted while he was employed by the Postal Service in Pompano Beach, Florida. Now, ever since my office has inquired about this scheduled award, Mr. Blystone has gone from having "permanent medical restrictions" according to Claudia Harris, Claims Examiner, to being terminated from receiving any medical benefits at all.

I am also concerned at the way in which he was examined by both Dr. Lauro and Dr. Tauberg. According to Mr. Blystone, neither doctor used any measuring devices to determine the extent of his injury, yet they were able to make the determination that he could go back to work without any medical restrictions.

William Staarman
August 4, 1998
page 2

It concerns me that the Office of Workers' Compensation would determine that "the weight of the evidence rests with the opinion of Dr. Tauberg" when he examined Mr. Blystone for a total of 15 minutes. According to Mr. Blystone, Dr. Tauberg spent more time examining his knee when this appointment was supposedly a second opinion appointment for his ankle. In addition, Mr. Blystone also claims that Dr. Tauberg sent him to get an x-ray for the wrong ankle and leg. When Mr. Blystone's wife asked him to change the prescription, he disputed the fact of which ankle and which leg were injured. Only after she showed him the medical documentation, did he make the change. It concerns me that the weight of the evidence comes from a doctor who spends minutes with the claimant rather than the doctor who spends years treating the injury.

Mr. Blystone's entire case is a result of mistakes made by both the Office of Workers' Compensation and the United States Postal Service. OWCP is supposed to do the follow-up work with the attending physician according to the Federal Employees' Compensation manual. This was not done, and Mr. Blystone's scheduled award fell through the cracks. The Postal Service was supposed to adhere to his medical restrictions and place him into a rehabilitation job, but that too fell through the cracks when he transferred to New Kensington.

Instead of resolving those mistakes, the Office of Workers' Compensation is terminating Mr. Blystone's medical benefits and taking him off of his restrictions. Mr. Blystone cannot work beyond those medical restrictions. He tried that when he first transferred from Pompano Beach, Florida, to the New Kensington Post Office because management was not adhering to his restrictions. The end result of that was another work-related injury. Mr. Blystone will now be forced to work beyond his limitations. When he cannot accomplish his tasks as a walking mail carrier, he will be terminated due to his inability to perform work related duties.

I would appreciate it if you will take all the evidence into consideration when making a final determination on his request for a scheduled award as well as his continuing medical benefits for Claim Number A60509895. In addition, please look at the enclosed documentation from Mr. Blystone's supervisor, Amy Barricklow. On the "Official Supervisor's Report of Occupational Disease," dated November 8, 1997, she writes, "he was hired as a mail processor and never had the ability to perform this clerk function." However, in a letter dated January 25, 1998, addressed to the U.S. Department of Labor, she writes, "Mr. Blystone transferred...as a mail processor. He began working this position and even worked overtime. He did an exceptional job as a mail processor and had no difficulty performing and completing his assignment." These two statements contradict each other which could and possibly may have affected his limited duty position.

As this is a complicated case, I would also appreciate it if you could set up a meeting in which Mr. Blystone and Tina Maggio of my staff could present all of the documentation regarding this case to the appropriate claims examiner so that all of the information can be taken into consideration when making the final determination.

William Staarman
August 4, 1998
page 3

Please keep my office up-to-date regarding this status of this case and my request. There are often times when phone messages are not returned to my staff, so I would appreciate your assistance in ensuring that my office will be communicated with regarding the progress of this case. If I can be of any assistance, please do not hesitate to call at (412) 241-6055. Thank you for your time and attention to this very urgent matter.

Sincerely,


Mike Doyle
Member of Congress

MD:tm
CC:Chuck Blystone

U.S. DEPARTMENT OF LABOR

Employment Standards Administration
Office of Workers' Compensation
3535 Market Street, Rm. 15100
Philadelphia, Pennsylvania 19104



August 19, 1998

AUG 25

The Honorable Mike Doyle
Member, United States
House of Representatives
133 Cannon Building
Washington, DC 20515

Dear Congressman Doyle:

I am writing to you in regards to the compensation claim of Charles T. Blystone, Case #A6-509895 and Case #A3-226839. Specifically, I'm writing in response to your letter dated August 4, 1998, received on August 11, 1998, concerning both cases.

Last week, the Senior Claims Examiner who'd been handling Mr. Blystone's cases, Ms. Toby Rubenstein, was unexpectedly detailed to Washington, DC for at least a six month period. We are now in the process of re-assigning her caseload to other Claims staff. As of this date, we are re-assigning Mr. Blystone's cases to a different Senior Claims Examiner, Ms. Barbara Williams.

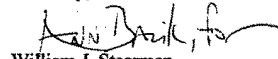
Regarding Case #A6-509895, you may be assured that Ms. Williams will thoroughly review all of the evidence submitted in response to the "Notice of Proposed Termination of Medical Benefits", dated July 21, 1998. Thereafter, a determination will be made as to whether the "Proposal" should be made final. A decision will also be made regarding Mr. Blystone's possible entitlement to a Schedule Award on this claim. In the event that the decision(s) would be unfavorable, Mr. Blystone would be provided with his full appeal rights. If favorable one(s) were issued instead, then all appropriate benefits will be expedited to the claimant.

Regarding Case #A3-226839, Ms. Williams must review the Second Opinion Specialist, Dr. Lauro's, report, as well as his supplemental report, in addition to the entire evidence of record. Mr. Blystone will then be further apprised concerning this claim.

You may be assured that Mr. Blystone will receive every FECA benefit to which he's entitled by law. All case actions will be performed as expeditiously as possible.

I trust that this is responsive to your inquiry.

Sincerely,

A handwritten signature in black ink, appearing to read "W. J. Staarman", with a stylized flourish at the end.

William J. Staarman
District Director

Chuck Blystone

*faxed to the
District Director
Sept 29, 1998*

I. Benefits terminated for A6-509895

OWCP - "all the medical evidence submitted by the claimant was already a part of the file except for an office note from Dr. Girdany dated 5/8/98 which states, 'His knee is bothering him more. His foot was not helped much by therapy. There is nothing more to do other than hyaluronic acid injections for the knee and perhaps a knee replacement. I injected his left foot in the area of the sinus tarsi, the site of removal of the ganglion, with Marcaine and Celestone. Hopefully, this will help him. He will return as needed.' Dr. Girdany does not discuss whether there is a relationship of the current foot condition to the 1991 work injury."

Blystone - Both Mr. Blystone and I submitted a letter from Dr. Girdany dated August 5, 1998 which does discuss his current foot condition in relation to the 1991 work injury. "I told him that some of his foot pain and his ganglion was likely related to his minor work injury and his resulting post-traumatic arthritis."

II. Evidence overlooked in Notice of Termination of Benefits from Toby Rubenstein

1. OWCP - Memorandum to the Director - States that Dr. Bacon made no reference to valgus deformity.

Blystone - Dr. Bacon's clinical records, dated 10/20/93 thru 4/5/94 he made reference to valgus deformity. "He has mild varus deformity of the forefoot bilaterally."

2. OWCP - State OWCP attempted to assist Dr. Bacon by sending him a form designed to elicit information in conformity with AMA Guides to Permanent Impairment but he did not respond.

Blystone - Dr. Bacon completed form 1303-06 on 4/5/94. Reading his clinical notes that day indicated that Mr. Blystone reached Maximal Medical Improvement and has Permanent Partial Impairment considered 15% of the left lower extremity as regards his foot. There is also a billing number for completion of this form, # C72-055. Also, if Dr. Bacon supposedly did not respond, it is the claims examiners responsibility to follow up on the case according to the FECA Manual. Also, why would OWCP send him this form, if Mr. Blystone was not being processed for a scheduled award.

3. OWCP - reference to a 1978 left foot fracture in Memorandum to the Director.

Blystone - 1978 was injury to the right foot; 1983 injury to left foot was a sprain with no mention of a fracture in the Brownsville General Hospital records, 015452. "Bony Structures are intact without evidence of fracture or dislocation."

4. OWCP - Dr. Langa and Dr. Taubert performed thorough examinations

Blystone - Both conducted examinations without medical measuring devices. Both were less than 15 minutes exams. Dr. Taubert had his injuries on different legs and thought Mr. Blystone was someone else.

5. OWCP - Weight of evidence is on Dr. Tauberg

Blystone - Dr. Tauberg and Dr. Bacon have the same credentials. Dr. Bacon was Mr. Blystone's attending physician for 4 years. His credentials were never challenged by the claims examiners in Florida when he stated Mr. Blystone reached Maximal Medical Improvement on 4/5/94. Mr. Blystone was never challenged on this claim even after he moved to Pittsburgh and changed physicians to Dr. Girdany.

6. OWCP - Mr. Blystone went from permanent medical restrictions and approved claims for physical therapy to termination of benefits once our office asked about scheduled award.

Blystone - letter from Claudia Harris indicates that Mr. Blystone has permanent medical restrictions to ankle injury.

7. OWCP - Dr. Bacon had placed medial restrictions on Mr. Blystone - no prolonged walking.

Blystone - 20 days after working beyond his restrictions in New Kensington, he had to receive pain therapy for left foot - injection.

8. OWCP - Memorandum to Director - Dr. Bacon prepared a very brief report about Mr. Blystones' permanent work restrictions.

Blystone - Claims examiner Dobyns from Florida was preparing a permanent limited duty job description within his limitations. She obviously had no doubt about Dr. Bacon's medical records and reports.

9. OWCP - Contradictory Statement by Amy Barricklow, supervisor at postal service at Greensburg Mail Processing Center in forms to OWCP

Blystone - 11/8/97 - "He was hired as a mail processor and never had the ability to perform this clerk function."
1/25/98 - "He began working this position (mail processor) and even worked overtime."

III. Questions still not answered by OWCP

1. Why did Mr. Blystone go from having "permanent medical restrictions" on claim # A6509895 to receiving a "Notice of Proposed Termination of medical Benefits" on that same claim? As soon as this office inquired about a scheduled award for Mr. Blystone, he was sent to see a second opinion doctor.

2. Why did it take only one month to make a decision on Claim # A6509895 after he saw the second opinion doctor, Dr. Tauberg? He still has yet to receive a decision on Claim Number A3226829 when he saw that second opinion doctor in April and the report came back indeterminate?

3. Why was Mr. Blystone not informed that Dr. Tauberg, the second doctor for Claim # A650985, would also be examining his knee injury, Claim # A3226839? According to the information that my office received, Mr. Blystone was there for an exam of his ankle and not his knee. I was told that he was definitely not there for his knee, just his ankle - even though Dr. Tauberg took an x-ray on his knee and examined his knee.

4. How can the weight of the evidence be placed on Dr. Tauberg when he only examined Mr. Blystone for 15 minutes, did not use any measuring devices, confused which leg had what injury, and spent most of that time examining his knee?
5. Why has the decision of Dr. Lauro, second opinion doctor for Claim # A3226839, not been used to make a final determination on Claim # A3226839. According to the report that Dr. Lauro submitted to OWCP, he stated that it is indeterminate as to when the aggravation of Mr. Blystone's work-related injury ceased. Mr. Blystone has been waiting since April 1998 to receive treatment on his knee and is still waiting for a decision to be made to seek further treatment.

MIKE DOYLE
18TH DISTRICT, PENNSYLVANIA
COMMITTEE ON SCIENCE
SUBCOMMITTEES:
ENERGY AND ENVIRONMENT
TECHNOLOGY

COMMITTEE ON
VETERANS' AFFAIRS
SUBCOMMITTEE:
HEALTH

DEMOCRATIC WHIP
SOPHOMORE CLASS

Mr. William J. Staarman
District Director OWCP
Department of Labor
Gateway Building, Room 15100
Philadelphia, Pennsylvania 19104



Congress of the United States
House of Representatives

September 10, 1998

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Dear Mr. Staarman:

Thank you for your recent response to my inquiry on behalf of Charles T. Blystone. Claim Numbers A6509895 and A3226839. However, it is not responsive to the issues I addressed in my last letter.

The following questions have yet to be answered regarding Mr. Blystone's case:

- 1) Why did Mr. Blystone go from having "permanent medical restrictions" on Claim Number A6509895 to receiving a "Notice of Proposed Termination of Medical Benefits" on that same claim? As soon as my office inquired about Mr. Blystone receiving a scheduled award for that claim, he was sent to see a second opinion doctor.
- 2) Why did it take only one month to make a decision on Claim Number A6509895 after he saw the second opinion doctor, Dr. Tauberg? He still has yet to receive a decision on Claim Number A3226839 when he saw a second opinion doctor in April.
- 3) Why was Mr. Blystone not informed that Dr. Tauberg, the second opinion doctor for Claim Number A6509895, would also be examining his knee injury. Claim Number A3226839? According to the information that my office received, Mr. Blystone was there for an exam of his ankle and not his knee.
- 4) How can the weight of the evidence be placed on Dr. Tauberg when he only examined Mr. Blystone for 15 minutes, did not use any measuring devices, confused which leg had what injury, and spent most of that time examining his knee?
- 5) Why has the decision of Dr. Lauro, second opinion doctor for Claim Number A3226839, not been used to make a final determination on Claim Number A3226839. According to the report that Dr. Lauro submitted to OWCP, he stated that it is indeterminate as to when the aggravation of Mr. Blystone's work-related injury ceased. Mr. Blystone has been waiting since April 1998 to receive treatment on his knee and is still waiting for a decision to be made to seek further treatment.

I would appreciate it if you would respond to the above questions. If my office can be of any assistance, please contact Tina Maggio at (412) 241-6055. Thank you for your attention to this matter.

Sincerely,

Mike Doyle
Mike Doyle
Member of Congress

MD:tm
CC: Charles Blystone

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Ms. MAGGIO. These documentations will demonstrate and provide insight into the attempts made to supply OWCP with the correct and factual information.

From these examples, I hope I have clearly demonstrated some of the problems I experienced in assisting constituents with their claims. To summarize, I often have problems getting my phone calls returned for constituent matters that are urgent. In addition, the response letters that I receive usually do not answer the specific questions and issues addressed in Representative Doyle's correspondence.

During my 3 years working for Representative Doyle, I have come to realize that most people go to their Congressman for assistance when they have exhausted all avenues on their own in trying to resolve their problems. When they come to the office, they are frustrated because they cannot get a response from their claims examiner regarding their specific questions.

Congressional casework entails getting those answers for those constituents. I feel that I am, at times, inhibited in this duty because of the lack of responsiveness and cooperation from OWCP. Most constituents want their Congressman's assistance in guaranteeing that they are getting a fair and equitable determination as well as getting the benefits for which they are entitled.

When I contact the district office, this is exactly what I'm trying to ensure. As a congressional caseworker, I'm here to help people either resolve their problems or answer their questions regarding OWCP. However, I am only one half of the whole in assisting a constituent. To do my job effectively, I need to be able to communicate with the responsive agency to ensure that the constituent is being treated in a fair manner.

Again, thank you for allowing me this opportunity, and I'll be happy to answer any questions.

[The prepared statement of Ms. Maggio follows:]

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18TH DISTRICT, PENNSYLVANIA
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Statement of Tina Maggio
before the
Subcommittee on Government Management, Information, and Technology
"Oversight of Customer Service at the Office of Workers' Compensation Programs"

Thank you Chairman Horn and Honorable Members of Congress for affording me this opportunity to submit a statement regarding my experiences in attempting to assist constituents with the Department of Labor's Office of Workers' Compensation Programs (OWCP) as a congressional caseworker.

I have been working in Representative Mike Doyle's district office as a field representative for three years this month. As part of my responsibilities, I assist constituents who approach the office with problems with OWCP. I also handle issues dealing with the Social Security Administration, the United States Postal Service, Medicare, and the Office of Personnel Management.

For OWCP cases, a majority of my contact is with the Philadelphia District Office. Occasionally, I will write or call the Branch of Hearings and Reviews Board in Washington, D.C. for an update on the status of a case, but most of my work deals with issues handled by the district office.

The Philadelphia District Office has a congressional phone number which is sometimes answered by an individual in the District Director's office. More often than not, a voice mail message is activated when I call. The message indicates that all congressional calls should leave a message with the constituent's name and his or her claim number.

In looking over the history of my casework, I have handled approximately 30-35 OWCP cases. These cases have varied in complexity. Some constituents simply request that I look into the status of their claim or their appeal. However, a majority of the OWCP cases on which I have worked are much more complicated. These cases deal with individuals not being reimbursed for pharmaceutical and medical expenses on approved claims, individuals having difficulty in obtaining approval for medical treatments, and individuals whose benefits have been terminated.

Since each individual case is different, I do not believe that it would be fair for me to make a generalized statement regarding the responsiveness of OWCP to congressional calls or correspondence. Therefore, I would like to provide a few examples of my constituent casework

in which I dealt with the claims examiners, the senior claims examiners, the supervisory claims examiner and the district director in the Philadelphia District Office. These examples cover problems regarding prescription reimbursement, compensation pay, and termination of benefits.

Example 1 - Prescription Reimbursement:

This individual is an employee with the United States Postal Service in Pittsburgh, Pennsylvania. He was injured on the job in an automobile accident which left him paralyzed. He has an approved medical claim through OWCP. I first spoke with this individual on March 8, 1999. He had been waiting for prescription reimbursements from OWCP since May 1998.

As a result of a paperwork mistake, his reimbursement checks were sent to the drug store in the drug store's name. He claimed that the drug store and his injury compensation specialist at the Postal Service tried to resolve this problem on many occasions by calling the Philadelphia District Office; however, their phone calls were not returned.

He was referred to seek assistance from Representative Doyle by the injury compensation specialist because neither she, the drug store, nor this constituent could get a response from the claims examiner at OWCP.

This individual explained to me that the medication he needed to be reimbursed for was to curb the shakes and shimmers he experiences as a result of the car accident. He told me that he was reducing the amount of his medication because he could no longer afford to pay for the prescription without getting reimbursed.

--On March 8, 1999, I contacted the Philadelphia District Office and left a message for his claims examiner to call me back on the main voice mail.

--On March 10, 1999, I contacted the Philadelphia District Office and left a message on his claims examiner's voice mail.

--On March 16, 1999, I contacted the Philadelphia District Office and left a message for his claims examiner to call me back on the main voice mail.

--On March 17, 1999, I faxed a letter to the District Director's office regarding this matter.

--On March 25, 1999, I called the congressional line and spoke with the assistant in the District Director's office. I told her that I had left numerous messages for the claims examiner to call me back over the past two weeks, but he had not yet called me back. She told me that all congressional calls are supposed to be answered within one day. She put me through to the supervisory claims examiner's voice mail and told me to call her back if I did not get a call within a day. I left a message for the supervisory claims' examiner to call me back.

--On March 26, 1999, I called and left another message on the main voice mail for either the claims examiner or the supervisory claims examiner to call me back.

--On March 29, 1999, I finally received a call from the constituent's claim examiner. This was three weeks from when I initially contacted OWCP. At this point, I asked him if he had received any of my messages. He told me that the only message he received was from the supervisory claims examiner to give me a call. I told him how many messages I left; however, he claimed that he did not receive any of them.

Once the claims examiner did call me back, he explained what this individual needed to do to resolve his prescription reimbursement problem.

Example 2 - Back Compensation Pay

This individual contacted Representative Doyle's office on March 8, 1999, for assistance regarding a mistake made in her compensation pay. For a four-week period in which she was entitled to compensation, she only received an amount equal to two weeks. In addition, she was owed compensation for the period from 12/6/97 to 12/25/97.

She addressed the problem of incorrect compensation payment in numerous letters to OWCP dated May 26, 1998; August 14, 1998; November 16, 1998; and January 11, 1999. She did not receive a response from OWCP regarding the compensation owed her. It was suggested to her to contact her congressman by the injury compensation specialist at the United States Postal Service because neither one of them could get a response from OWCP regarding this matter.

--A letter dated March 8, 1999, was sent to the District Director from Representative Doyle regarding this matter.

--In a letter dated, March 26, 1999, but not received until April 13, 1999, the District Director stated that a compensation payment was made to the constituent for the time period from 12/6/97 to 12/25/97. In addition, he claimed that an adjustment check was sent to her on May 8, 1998. If she did not receive it, then she should file for a non-receipt.

On April 13, 1999, the constituent called me to let me know that she finally received the payment for the back compensation owed her.

Example 3 - Termination of Benefits:

I have been working with this individual since September 1997. This individual has two work related injuries with the United States Postal Service.

His first injury occurred to his left ankle while employed in Pompano Beach, Florida. It was an approved claim in which his medical restrictions were also approved by OWCP. He was being

assigned to a rehabilitation job in Pompano Beach before his transfer to Pittsburgh. After his transfer to Pittsburgh, he was informed by his claims examiner in writing that the ankle injury and restrictions were permanent according to OWCP.

When he transferred to Pittsburgh, he was assigned to walk a six-hour mail route. When he informed his supervisor that it was beyond his work restrictions for his work related injury, he was told to complete the mail route because management was not aware of his limitations when the transfer was approved. While on the mail route, he fell through a set of wooden steps and injured his right knee. Since this second injury, there have been many complications with this individual's claims.

This individual first came to Representative Doyle's office when he realized that he was due a schedule award for his ankle injury sustained in Pompano Beach. When reading through the Federal Employees Compensation manual, he realized that the OWCP district office in Pompano Beach was processing the paperwork for a schedule award for his ankle injury. His doctor was requested by OWCP to fill out the proper paperwork, Form CA-1303, which determines permanent partial impairment and maximal medical improvement. Therefore, he asked me to find out if he was entitled to a schedule award. He was also awaiting a decision on his right knee injury for which he had already seen a second opinion doctor.

--A letter was submitted to the District Director from Representative Doyle regarding this individual's schedule award. In a letter dated June 9, 1998, this individual was informed that he would have to go to an OWCP doctor for a second opinion examination to see if there were any residuals from his ankle injury and if he was still entitled to benefits.

--I called OWCP on June 16, 1998, and left a message for his claims examiner to call me back regarding this appointment.

The individual saw the OWCP doctor on June 22, 1998. He contacted me soon after to inform me that the OWCP doctor, who was supposed to be examining his ankle, spent more time examining his knee, the other work-related injury. He also claimed that this doctor was at first examining the wrong ankle and the wrong knee. The doctor sent him x-rays for the wrong sides of the body. This individual asked me to call OWCP to find out why this doctor was examining his knee.

--I called OWCP on June 22, 1998, and left another message for his claims examiner to call me back regarding this appointment.

--I called OWCP on June 23, 1998, and left another message for his claims examiner and a message for the supervisory claims examiner to call me back regarding this appointment.

--On June 24, 1998, the supervisory claims examiner called me back and informed me that this appointment was for a second opinion examination for his ankle injury. She also told me she was assigning both cases to a senior claims examiner because of the complexity of this individual's cases.

--On June 26, 1998, I contacted the supervisory claims examiner again. I asked her about the second opinion doctor examining the constituent's knee and she told me that the exam was for a second opinion on his ankle injury only and it had nothing to do with his knee injury. I asked her why the doctor was examining the knee then? She told me that we would all have to wait until the doctor's opinion came in before we could dispute anything.

In the doctor's opinion to OWCP dated June 26, 1998, he makes determinating statements regarding this individual's knee injury in addition to his ankle injury.

--On June 29, 1998, I called and left a message for the senior claims examiner to discuss the schedule award and the second opinion doctor exam.

The individual received a Notice of Proposed Termination of Medical Benefits dated July 21, 1998, for his claim for the ankle injury.

--On July 27, 1998, I left a message for the senior claims examiner to call me back.

--A letter dated August 4, 1998, was sent to the District Director from Representative Doyle addressing the misinformation and facts that were incorrect in the Notice of Proposed Termination of Medical Benefits and Memorandum to the Director. Medical evidence and documentation were provided to support the statements made in the letter. In addition, a meeting was requested with the District Director for the constituent and myself.

--On August 20, 1998, the same letter that was submitted to District Director on August 4, 1998, was also sent to the Regional Director.

--On August 25, 1998, I received a letter from the District Director which stated that this constituent's case was reassigned to another senior claims examiner who would thoroughly review all the evidence. None of the questions addressed in the August 4, 1998, letter were answered.

--On August 31, 1998, I left a message for the senior claims examiner to call me back.

--On September 3, 1998, received a letter from the Regional Director stating the same information as was in the District Director's August 25, 1998, letter.

--On September 10, 1998, another letter was sent to the District Director from Representative Doyle outlining the five specific issues and questions that had not yet been answered by his office. It was stated in the letter that the District Director's past correspondence was not responsive to the issues previously addressed.

In a letter dated September 24, 1998, this individual's benefits were terminated.

--On September 29, 1998, I faxed a list of unanswered questions to the District Director's office. When I contacted him to go over them point by point, I spoke with his assistant who told me that the District Director would call me back once he had the chance to review the information.

--In a conversation with the District Director on October 1, 1998, I was told that his senior claims examiner is very thorough and he puts his complete trust in her decision. I attempted to explain to him the incorrect facts she stated in her termination of benefits as well as point out the evidence that was overlooked in making the determination. I had supporting documentation for every statement. This documentation had been sent to the senior claims examiner prior to the final determination being made. He told me that there was no point in discussing it because the constituents can appeal the decision and bring it up then. I told him that all of this was submitted before the final termination decision was issued and should have been considered then. I asked if he would review the individual's file to gain a greater understanding of our concerns in how this claim was handled. He said that he would not do that.

This individual received a response from the District Director dated October 29, 1998, which detailed the responsiveness of OWCP to both the individual and Representative Doyle. The District Director states that all phone and written inquiries received from Congressman Doyle's Office have been promptly answered by the Philadelphia District Office.

The constituent appealed for a hearing with the Branch of Hearings and Reviews. Before his case even made it to the hearing, the hearing representative reversed the decision of the district office and remanded the case back for a referee doctor in a decision letter dated January 19, 1999. The hearing representative stated that the office did not meet its burden to justify the termination of compensation benefits, and the medical benefits must be reinstated retroactive to their termination.

This case is still pending an appointment with a referee doctor. This has been delayed because OWCP first scheduled this individual for a referee appointment with a doctor who performs fitness for duty exams for the United States Postal Service. According to the FECA manual, a doctor who performs fitness for duty exams for the employing agency cannot perform the referee examination.

--Since this individual is scheduled for knee replacement surgery due to his other injury, I sent a letter on April 21, 1999, to the individual's claims examiner requesting that his appointment with the referee doctor be scheduled before his knee replacement surgery at the beginning of May 1999.

--On April 27, 1999, I left a message for his claims examiner to call me back on the main voice mail regarding the scheduling of the referee examination.

--On April 28, 1999, I left a message for his claims examiner to call me back on the main voice mail regarding the scheduling of the referee examination.

--On April 29, 1999, I left a message for his claims examiner to call me back on the main voice mail regarding the scheduling of the referee examination.

In a letter dated May 7, 1999 from his claims examiner, this individual was denied his request for the schedule award for his ankle injury even though he has not yet gone through the referee examination.

--As of May 14, 1999, I have not received a returned phone call from his claims examiner.

--On May 14, 1999, a letter was sent to the District Director from Representative Doyle requesting a justification of the denial of the schedule award before the medical report from the referee doctor was received and reviewed by OWCP. Under the orders of the hearing representative, the referee doctor will provide a clarification of the contradicting medical reports from the individual's doctor and the second opinion doctor.

From these few examples, I hope I have clearly demonstrated some of the problems I experience in assisting constituents with their claims with OWCP. To summarize, I often have problems receiving a returned response by phone for constituent matters that are urgent. When I have addressed this fact with the District Director in the past, he has responded that according to his records, all of my phone calls are returned. In addition, the response letters that I receive usually do not answer the specific questions and issues that have been addressed in Representative Doyle's correspondence to OWCP.

During my three years working for Representative Doyle, I have come to realize that most people approach their congressman for assistance when they have exhausted all avenues on their own in trying to resolve their problems. When they come to the office, they are frustrated because they cannot get a response from their claims examiner regarding their specific questions. Congressional casework entails getting those answers for the constituents. I feel that I am at times inhibited in this duty because of the lack of responsiveness and cooperation from OWCP.

When it comes to OWCP, most constituents are not looking for their congressman to influence a decision in their favor. A majority of individuals want their congressman's assistance in guaranteeing that they are getting a fair and equitable determination based on the merits of their case as well as getting the benefits for which they are entitled.

When I contact the OWCP district office on behalf of a constituent, I am trying to ensure that each individual is getting exactly what is outlined in the Federal Employees Compensation manual.

Per the policy and procedures of Representative Doyle, we cannot pick and choose the constituents who need assistance, nor do we pick and choose those we do help. Every constituent in the 18th Congressional District of Pennsylvania has the right to call upon Representative Doyle in assisting with a problem with a federal agency, and every constituent can count on whatever assistance we are able to provide to their situation. It is up to us, congressional caseworkers as a whole, to act as liaisons in requesting information and status reports or requesting prompt consideration of a matter based on the merits of the case.

As a congressional caseworker, I am here to help people either resolve their problems or understand the benefits for which they are entitled. However, I am only one half of the whole in assisting a constituent. To do my job effectively, I need to be able to communicate with a responsive agency to ensure that the constituent is being treated in a fair and equitable manner.

Again, thank you for allowing me this opportunity.

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Mr. HORN. Let me just ask one here. You handle other than cases such as this. You probably have Social Security cases, Medicare cases, Internal Revenue cases, Immigration cases.

Ms. MAGGIO. Right.

Mr. HORN. As you look at all of those agencies with which you connect on behalf of Representative Doyle, which is the most responsive and which is the least responsive?

Ms. MAGGIO. The most responsive is Social Security Administration. They have a congressional office in Baltimore that is very responsive. The least responsive is OWCP in Philadelphia.

Mr. HORN. I thought that would be your answer. Without question, I served on the Senate staff in the early 1960's. Then and now, I think most of us say the best run organization in the U.S. Government is the Social Security Administration.

I had an interesting experience when I came back from a long day of committee hearings about a month ago, I saw a fax from an attorney in Long Beach, CA, where Social Security hadn't come through on the check that they admitted he knew. So, even good agencies make their mistakes.

So, I wrote out a fax to the Commissioner in Baltimore and within 18 hours he had a response back to me. The check was out there, and he apologized on the behalf of the agency for the stupidity of one of his members. That's a very responsive operation. So thank you for adding that to our record.

I'm now going to have the vice chairman do the questioning, Mrs. Biggert of Illinois.

Mrs. BIGGERT. Thank you, Mr. Chairman.

Ms. Balen, you talked about the time it takes to get a case number. Is it—what does it entail to get a case number? Isn't it just an assignment of a number?

Ms. BALEN. I don't know.

We're really not in on that part of the process. All we know is either the patient comes to us with a new injury that is—they say is workers' comp, and they work for the Federal Government and we know they have these forms. There's one particular form that we do fill out, I think it's the CA-16 that, according to my information, is the form that is required to initiate the process for getting a case number.

What has to happen beyond that point, I really don't know. I just know it kind of takes a long time. Eventually the patient is issued—we've had them come in with a little card with their case number on it. If we have treated the patient without a case number and we're waiting, holding the bill, sometimes the patients don't realize that as soon as they get that little card with the case number, that they need to give it to us. I don't know if it's not stressed to them, that you need to go give that to everybody who has helped you with this. I don't know what process they're having to go through.

Mrs. BIGGERT. Mr. Linehan said that many times since they can't get a response from OWCP that they have gone to the private insurance. Do you find that happening?

Ms. BALEN. We typically have not done that because what we find, at least in my office, all insurances want to know how the injury happened and where you were. And as soon as you say it hap-

pened at work, they won't touch it. I think that's a good idea if it would work. We haven't found that it really works.

Typically what we've done if we have a patient who is like the one in my example in my statement, we usually just go ahead and do the surgery and try to get the authorization later which means the patient ends up getting helped, but we end up holding the bag.

Mrs. BIGGERT. Since you've had to—the amount of money is so much lower than other—is it lower than what was paid out in the State for workers' comp?

Ms. BALEN. Oh, far lower. Yes, I've got that in my statement. Typically the State Worker's Comp allows more than what we charge, which is kind of backward. But, yes, the USDOL typically pays less than half of our charge, and the State Worker's Comp allows more than we charge. So it's a considerable difference.

Mrs. BIGGERT. So you just have to write that off.

Ms. BALEN. Yes.

Mrs. BIGGERT. OK. Mr. Riordan, do you find problems with the numbers also?

Mr. RIORDAN. Well, the number is assigned once a case worker looks at a case. I mean, there is a delay. And if you call before you're assigned a case number, they can't help you, they won't help you. You have to have the case number. So you just have to sit and wait until it's looked at.

Mrs. BIGGERT. Do you find that some people will go through private insurance rather than the workers' comp, or do you find the same thing that Ms. Balen said?

Mr. RIORDAN. Yeah, I don't think they're covered by—if they're injured at work, they have to file for workers' comp.

Mrs. BIGGERT. OK. Mr. Linehan, why is it that there's so few lawyers that are willing—I'm a lawyer also and I've never done a workers' comp case, but why are there so few that are willing to take these cases?

Mr. LINEHAN. A carpenter needs tools to work. An attorney needs a court to work in. There's no court. There is nothing really for an attorney to work with.

Basically, I push the claim. I help—claimants come into me after they have grown so frustrated with the system, they basically come in to me, throw a file down on my desk that averages a foot thick and say, "Take it and run with it. We don't want to mess with it. We'll pay you whatever it takes to handle this. Just do something to get this moving."

That's where I enter the picture. I don't enter the picture at the beginning of the claim. The claimant is hurt and they come to me rarely, if ever.

Mrs. BIGGERT. Are there States that you know of that have some access to the courts from workers' comp cases?

Mr. HORN. Can we move the mic a little closer to each of you. It's a little difficult to hear.

Mr. LINEHAN. I don't understand your—you mean State comp?

Mrs. BIGGERT. Well, since there's no Federal process to get into court, are there State courts that take appeals from workers' comp?

Mr. LINEHAN. Federal OWCP?

Mrs. BIGGERT. No, from State.

Mr. LINEHAN. Oh, every State.

Mrs. BIGGERT. Every State?

Mr. LINEHAN. Yeah. Oklahoma, you have the Oklahoma OWCP system, it's appealable to the State Supreme Court up through the circuit courts, et cetera.

Mrs. BIGGERT. Do you know of any reason why this hasn't happened on the Federal level?

Mr. LINEHAN. I'm not going to comment, but yeah. It's just—you've got a system that works as it is now for the system. It doesn't work for the claimants. From what I see, claimants who come in are scared to death. They don't want to buck the system. They don't want it to be known that they're bucking the system.

So the system continues, it grows on itself. And that's what's happened here. Nobody is bucking the system. They're scared. Maybe that's why I'm here. But something needs to change. And the only change I could see that needs to be done that will really work—that will end a lot of these problems overnight—is allowance for Federal court review.

And I don't know of any reason why these civilians should be treated any differently from any other injured, diseased or killed civilian in America. But they are. They are. They have no rights. Zero.

Why is that? That is a question that goes back to the Congress.

Mrs. BIGGERT. Thank you.

Ms. MAGGIO, have you had complaints about second opinions or doctors? Is that—

Ms. MAGGIO. Yes. I have a long, involved case. It's actually the case example, the termination of benefits in my written statement. His second opinion exam was about 15 minutes long. The doctor was supposed to be examining his left ankle, I believe it was his left. He was examining the right ankle.

And he was also examining another injury that he had—another work-related injury that he wasn't supposed to be examining. And he sent him for x-rays for the wrong ankle, the wrong knee. And the OWCP based terminating his benefits on it—they put the weight of the evidence in that doctor's assessment.

Mrs. BIGGERT. Fortunately they weren't doing surgery.

Ms. MAGGIO. Right. Right.

Mrs. BIGGERT. In a second opinion, is it usually the same doctor over and over again in the area that would be giving the second opinion?

Ms. MAGGIO. You mean many constituents going to the same second opinion?

Mrs. BIGGERT. Yes.

Ms. MAGGIO. I have seen a couple of the same doctors' names popping up with different constituents who come to the office. I don't know how often—I was told that it's a revolving process where it's kind of they draw a name and they send the constituent to that doctor.

But I'm not sure how often they go to the same one.

Mrs. BIGGERT. Do you sense, then, that their decisions are pre-determined?

Ms. MAGGIO. Yes, I get that feeling. And I believe that—I have one constituent who knows the FECA manual front and back, and luckily—because he knows what his rights are. But I think that at

times OWCP tries to send these individuals to doctors, especially for a referee exam, you cannot go to a fitness-for-duty doctor for the employing agency.

And I think a lot of claimants are going to doctors who are also working for their employing agency, which is a problem. There is a conflict of interest there.

Mrs. BIGGERT. I know that in so many States the second opinion is the choice of the injured worker and there has been some movement to change that; to have the employers have the opportunity to choose the second doctor. So you don't think that would be a good idea on the Federal level?

Ms. MAGGIO. No. No.

In my opinion, I deal a lot with postal workers who are injured. And I think there's a rush to get people back to work. And I think that if the employer was able to choose the doctor, the second opinion doctor, that might have some influence on the decision of the doctor. It's just my opinion, but I think it would be best if it was an outside source.

Mrs. BIGGERT. Thank you.

Thank you, Mr. Chairman.

Mr. HORN. Thank you very much.

Is there any additional point you feel has not been made that you would like to make? This is the last call on that.

Ms. Balen.

Mr. Riordan.

Mr. RIORDAN. Well, one earlier question Congresswoman Biggert asked was why is there a delay in processing, asked one of the earlier people that testified, why is there a delay.

Well, one of the reasons is the agency has an interest in keeping the employee off workers' comp because the agency has to cover the position for a full year. So they want the employee back to work because that position is open. And their statistics count against that employee for production purposes. So they want to pressure the employee to come back to work.

That's why the personnel offices have delays, you know, delays in processing and filling out the forms and completing them and sending them to OWCP. That's part of it, any way.

Mr. HORN. Mr. Linehan, anything else you want to say?

Mr. LINEHAN. No. I appreciate the opportunity to be here. And if you have any further questions of me, I would be happy to answer them.

Mr. HORN. Well, if something comes to mind, if you don't mind we'll do what we do with every other hearing, send you the question and at this point in the record, we'll give the question and your answer.

[The information referred to follows:]

Thomas Chamberlin/Sheila Williams Conversation

You invited me to provide information concerning the testimony of Thomas Chamberlin and his conversation with Acting FEC Director Sheila Williams. Mr. Chamberlin called the OWCP national office, in follow-up to his faxed message, to determine what appeal options were available to him following a decision of the Office on November 5, 1998. Having no direct knowledge of the case or the recent decision, Ms. Williams explained to Mr. Chamberlin that she was on her way out of town but would ensure that he got a response to his question. She referred the faxed inquiry to the responsible Claims Examiner handling his case in the district office. Unfortunately, no response to Mr. Chamberlin was in fact provided at that time by the district office.

Following these events, Mr. Chamberlin in fact requested and received a review of his case file under 5 USC 8128, which was the appeal opportunity he had been seeking. A decision on the appeal (reconsideration) was issued on July 21, 1999, and his further appeal right to the Employees' Compensation Board is described in the decision letter. Acting Director Williams wrote separately on July 22 to Mr. Chamberlin apologizing for the initial failure to respond and the resulting delay. After the situation was brought to their attention, the district office made specific improvements to ensure that future written requests would be handled timely.

Ms. Williams and I greatly regret that Mr. Chamberlin did not receive the information he sought from us. I can assure you again, as I did on May 18, that it is not characteristic of Ms. Williams, who has served OWCP with distinction as Deputy Director of the FECA program since 1990 and as Acting Director since March 1999. In addition to her excellent management of this complex program, she is personally extraordinarily accessible and responsive to claimants, often going to extraordinary lengths to ensure that a payment is expedited or a question answered.

ATTACHMENT A

Report on New York Regional Office Allegations

Chairman Horn requested that Deputy Director Hallmark investigate the allegations of Ms. McGuinness and Mr. Riordan to the effect that OWCP New York Regional Director Kenneth Hamlett behaved improperly or abusively in dealing with Ms. McGuinness and her FECA claim. Mr. Hallmark and members of his staff have reviewed available records in this regard, and discussed the matter in some detail with Mr. Hamlett and members of his staff who witnessed some of the exchanges.

Mr. Hamlett provides a different description of the September 16, 1996, hallway encounter complained about by Mr. Riordan and Ms. McGuinness. Mr. Riordan's statement suggests that he and Ms. McGuinness were outside the FECA office attempting to deliver a package of papers which constituted an appeal of her claim. He acknowledged that Mr. Hamlett ultimately accepted (and signed a receipt for) these documents, but describes Mr. Hamlett as shouting, visibly upset, disturbed, and unwilling to listen to their responses.

The office had earlier during that year instituted a new security policy to address serious threats of violence against office employees by disgruntled claimants. The policy was precipitated by the arrest of a disturbed claimant who had made numerous threats against the New York OWCP staff and whose psychiatrist had reported to the FBI that the threats were credible. The policy was also intended to provide assurance that OWCP staff would be protected from other risks: during late 1995 both a murder and an armed robbery which resulted in a stabbing occurred in the building. While not all FECA offices have instituted such a controlled approach to walk-in visitors, all have installed security protections and strictly limit public access, for similar reasons. The circumstances in the New York office, especially given the presence of an INS detention center in the same building, justified the additional precautions.

Mr. Hamlett states that he observed two people attempting to gain entry into the FECA office, through a locked door clearly marked "staff only". Concerned about a potential security breach, he spoke to them loudly enough to be heard down the hall as he walked quickly towards them to determine what they were doing. Mr. Hamlett reports that once the parties had identified themselves the conversation was civil on all sides, and Ms. McGuinness's desire to deliver a package of documents was accomplished, as Mr. Hamlett accepted the papers and had them associated with the case file. But he did deny access to the office, and explain that Ms. McGuinness would have to return another time when she had an appointment, in accordance with the office's policy. Although Mr. Riordan expressed "shock" that the Regional Director would intervene in this way, in fact his actions appear to have been appropriate, especially when he determined who Ms. McGuinness was. (He knew that a claimant by that name had been advised by an office representative that she could not have an appointment for that day, because the responsible claims examiner was not there to meet with her). It is regrettable that Mr. Riordan and Ms. McGuinness were unhappy at being informed of OWCP's policy and at having the restrictions on visiting the office enforced, but it also appears that Ms. McGuinness was attempting to circumvent the procedures for obtaining an appointment

ATTACHMENT B

that had been explained to her earlier. The circumstances in this instance were quite unusual, but Mr. Hamlett's conduct was hardly "shocking," and his intervention appears to have been in keeping with the situation as he understood it.

Mr. Riordan and Ms. McGuinness also cite a telephone conference call with Mr. Hamlett and others in the New York office that occurred two days later, as a further example their disappointment with Mr. Hamlett's customer service. Although both witnesses expressed objections to the specific claims processing actions Mr. Hamlett attempted to explain during that call (e.g., the method of selecting a medical referee to resolve the medical disputes regarding her continuing claim of disability), the central concern appears to be the tone and aggressiveness of OWCP's communication in this instance.

Mr. Hamlett and the three other OWCP employees present acknowledge that the communication in this instance was heated at times. Mr. Hamlett denies that he spoke "in an angry and loud tone", although it is clear that the call became contentious and that at times he and Ms. McGuinness talked over one another. Mr. Hamlett reports that the reason for the conference call was at least in part to attempt to resolve a growing difficulty in communicating with Ms. McGuinness. He had been advised that she had called several different staff members repeating the same questions and complaints; there was a confusion as to who her designated representative was (an individual other than Mr. Riordan had been acting in that capacity and she had not clearly stated which was currently authorized), and Ms. McGuinness had written many letters to different officials, seeking redress for her concerns. Mr. Hamlett hoped to use the conference call to see that a clear understanding of the current actions being taken on her case was shared by all, and to attempt to streamline communications in the future such that she or her representative contacted the responsible examiner in a one-to-one fashion to avoid further confusion and duplicative efforts.

Clearly, the call did not accomplish those goals. Mr. Riordan states that he did not understand the reasoning for various claims decisions, and the claimant continued to be extremely unhappy with the handling of her case. In hindsight, Mr. Hamlett's attempt to clear the air in this instance was unsuccessful, and he might have chosen some other communication vehicle. The participation of the Regional Director, the District Director and two claims examiners indicates that OWCP's intent was to use this call to resolve problems, not to ignore them. The office made a continuing effort to effectively communicate with Ms. McGuinness throughout the handling of her case, including responses to more than 40 Congressional letters and other priority inquiries made on her behalf between 1995-1998.

OWCP seeks to achieve satisfaction with our services for all our customers, but in some instances the law, regulations and procedures we must apply result in actions that are either unfavorable to the claim or are viewed as undesirable by the claimant. Some individuals continually press their arguments notwithstanding having been provided a thorough description of the actions being taken, their rationale, and the opportunities for due process that will be afforded should they disagree. The circumstances and claims actions are sometimes complex. They can involve multiple injuries, non-work-related or

disputed medical conditions, conflicts over job suitability in light of the injury, disagreements over the coverage of alternative medical treatment options, and a myriad of other issues. These difficulties and disagreements can arise even while OWCP is providing ongoing compensation for the claimant's wage loss and medical costs -- as was the case for Ms. McGuinness before, during, and for several months after the confrontations under discussion here.

It is regrettable when our efforts to communicate fully yield disappointment and verbal conflict. Our staff are trained to avoid expressions of impatience or frustration insofar as humanly possible in these instances, and we expect them to bring such conversations to a polite close when it appears that they can no longer be fruitful. It would appear that this conference call was an example of this difficult type of interaction, and clearly Mr. Riordan and Ms. McGuinness were not at all satisfied with either its substance or its tone. Just as clearly, the New York office made extensive and intensive efforts to address Ms. McGuinness' inquiries and requests. Mr. Hamlett, like all OWCP employees, will nevertheless continue to work to improve the efficacy of our communication techniques.

Finally, it is noted that during the hearing we were asked to review and respond to a tape recording or transcript which Ms. McGuinness was to submit regarding a separate telephone conversation, ostensibly between her and Mr. Jonathan Lawrence, the New York FECA District Director. We have not been provided a copy of this document, and while Mr. Lawrence recalls several conversations with Ms. McGuinness, he is not sure he recalls the specific conversation she describes in her written statement. He does recall a conversation with a woman who did not identify herself, in which a complaint was lodged about the policy denying access for walk-in meetings without an appointment. If that is the call which Ms. McGuinness taped, the issues discussed above regarding Mr. Hamlett's hallway discussion would likely be applicable to this conversation as well.

Alaska Medical Fee Schedule

Ms. Beth Balen raised concerns about OWCP's fee schedule for certain medical services, indicating that we pay less than the Alaska workers' compensation program allows for the same services.

Background

In 1986, The Office of Workers' Compensation Programs (OWCP) published regulations (March 10, 1986, 51 FR 8276-82) that established a fee schedule for the reimbursement of charges for medical services incurred during the treatment of injuries covered under the FECA. This schedule, which was based on the relative unit value system developed by the Division of Labor and Industry, State of Washington, the Physician Procedural Terminology (CPT-4) coding scheme, and internally developed conversion factors, was national in scope, and allowed for regional variations in medical costs through a geographic index. Development of the fee schedule was prompted by the Office of the Inspector General (OIG) recommendation that OWCP institute corrective actions to prevent suspected billing abuse by physicians.

OWCP used this initial version of the fee schedule for four (4) years. However, in 1992, the Health Care Financing Administration (HCFA) implemented a fee schedule to regulate payments for professional medical services provided under the Medicare Program, and two years later OWCP adopted HCFA's model by regulation (February 23, 1994, 59 FR 8529-30). The revised schedule, which is still in effect, retains the CPT coding scheme, and the internal conversion factors, but uses the resource based relative value units (RBRVUs) and the geographic adjustment factors developed by HCFA for the Medicare program. All elements are updated every year. The CPT codes, RBRVUs and geographic adjustment factors are obtained from HCFA, while the conversion factors updates are based on the Medicare medical economic index and our own internal medical payment data.

Nationally, the OWCP fee schedule reduces about 22% of the total amount billed for professional medical services. When compared to the 35 state workers' compensation medical fee schedules in effect at this time, the OWCP reimbursement level is approximately at the 50th percentile. That is, there are as many states that have lower reimbursement rates as there are states that have higher payment levels. Additionally, a number of states, among them Texas, Pennsylvania and California, have used the OWCP schedule as a reference when updating their own schedules. (It is important to note that the OWCP payment levels which were cited as too low during the hearing are in fact substantially higher than the amount Medicare pays for the same service, utilizing the HCFA fee schedule. This is in part because workers' compensation services entail additional requirements including report writing, and because Medicare utilizes a patient co-pay system whereas FECA and typical workers' compensation systems pay the total cost.)

Current Status

We have studied our FY 1998 medical payments in Alaska. Charges for services amounted to \$1.96 million, and \$1.40 million, or 72%, was paid to health care providers. Clearly, this reimbursement level is lower than our national average. Moreover, while payments for office visits amounted to 80% of the total billed, for other services, particularly surgery and radiology, the reductions exceed 28%.

Each year HCFA makes adjustments to its fee schedule components, and OWCP uses those adjustments to update our own system. The 1999 fee schedule update we have recently implemented addresses some of the issues raised by Ms. Balen, and similar concerns expressed to OWCP's Medical Director during a meeting of the Alaska Medical Association she attended last May. Based on a review of 1998 nationwide payment data, all OWCP conversion factors have been increased by 2.3% (the medical economic index), while the surgery and radiology conversion factors have been increased by 14% and 9 % respectively. When these changes are combined with the HCFA's 1999 RBRVU and geographic adjustment factor updates, it is calculated that payments for surgery and radiology will generally increase by approximately 13%. Payment for other services (e.g., office visits), will increase by considerably less.

Changes in reimbursement rates in specific geographized areas can only result from changes to the geographic adjustment factors, which we incorporate in our system wholly on the basis of the HCFA-developed structure. For this reason, we discussed the Alaska factors with HCFA's Division of Practitioner and Ambulatory Care. Because the methodology and the data used for the calculation of the adjustment factors is set by law, they do not foresee any change in the geographic adjustment factors until 2001, when they will complete their next scheduled review. Short of jettisoning entirely the HCFA structure (and their system is based on far more extensive and reliable cost data than OWCP could hope to generate), OWCP is unable to substitute its judgement for the geographical adjustment factors derived from that system.

However, HCFA does have permission to add a 10% bonus for Medicare payments in areas designated as "Health Professional Shortage Areas" (HPSAs), and most of Alaska is included in this category. HCFA has formally recommended the adoption of such a bonus to other federal users of the HCFA schedule, including the Department of Veterans Affairs, CHAMPUS, and the Department of Defense (DOD), who have reported reimbursement problems in Alaska, Hawaii and Puerto Rico. OWCP will consider the addition of this differential to our payments in Alaska and other professional shortage areas as identified by HCFA.

Summary

OWCP (1) met with the Alaska Medical Association on May 25, 1999 and reviewed their concerns about its payment structure; (2) reviewed our fee structure in light of these issues and made FY 1999 adjustments that will increase reimbursement for key service types that Ms. Balen and other Alaska medical providers feel have been undervalued; (3)

approached HCFA regarding the complaints we have heard from Alaska that the geographic cost factors for that region are too low, and have been advised that HCFA is aware of this concern and is evaluating a long-term fix; and (4) is considering application of an interim "bonus" adjustment which HCFA has implemented as a means of addressing relative cost issues in areas where provider shortages are prevalent.

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Washington, D.C. 20210

File Number:



July 26, 1999

The Honorable Jim Turner
Ranking Minority Member
Subcommittee on Government
Management, Information, and Technology
House of Representatives
Washington, DC 20515

Dear Congressman Turner:

This is in response to your letter of July 19, 1999, requesting that OWCP clarify its rules regarding federal employees' benefit claims under the Federal Employees' Compensation Act (FECA). The following responses to your questions are submitted for inclusion in the record of the Hearing held before the Subcommittee on Government Management, Information, and Technology on May 18, 1999.

- (1) Does the Department of Labor, under § 8128 of the FECA, have the authority to review OWCP decisions to end, decrease, or increase any award of compensation benefits paid to a beneficiary?

OWCP cannot unilaterally revise an award of compensation benefits without possibility of review. Section 10.610 of the regulations implements § 8128(a) of the FECA and provides the following:

The FECA specifies that an award for or against payment of compensation may be reviewed at any time on the Director's own motion. Such review may be made without regard to whether there is new evidence or information. If the Director determines that a review of the award is warranted (including, but not limited to circumstances indicating a mistake of fact or law or changed conditions), the Director (at any time and on the basis of existing evidence) may modify, rescind, decrease or increase compensation previously awarded, or award compensation previously denied. A review on the Director's own motion is not subject to a request or petition and none shall be entertained.

(a) The decision whether or not to review an award under this section is solely within the discretion of the Director. The Director's exercise of this discretion is not subject to review by the ECAB, nor can it be the subject of a reconsideration or hearing request.

(b) Where the Director reviews an award on his or her own motion, any resulting decision is subject as appropriate to reconsideration, a hearing and/or appeal to the ECAB. Jurisdiction on review or on appeal to ECAB is limited to a review of the merits of the resulting decision. The Director's determination to review the award is not reviewable.

As noted in subsection (b) above, any decision issued as a result of the Director exercising his discretionary authority under § 8128(a) would be accompanied by appropriate appeal rights, as are any other decisions of the OWCP.

(2) What type of notice is the OWCP required to give a FECA beneficiary prior to a reduction or termination of compensation?

OWCP's regulations require that a FECA beneficiary be given advance notice of the intention to terminate or reduce his or her compensation. Section 10.540 of the regulations directs that "where the evidence establishes that compensation should be either reduced or terminated, OWCP will provide the beneficiary with written notice of the proposed action and give him or her 30 days to submit relevant evidence or argument to support entitlement to continued payment of compensation," provided that the beneficiary has a "reasonable basis to expect that payment of compensation will continue" and compensation is not being terminated, suspended or forfeited due to a penalty provision of the FECA or the implementing regulations. These notices include "a description of the reasons for the proposed action and a copy of the specific evidence upon which OWCP is basing its determination." Payment of compensation continues "until any evidence or argument submitted has been reviewed and an appropriate decision has been issued, or until 30 days have elapsed if no additional evidence or argument is submitted."

(3) Is a FECA beneficiary entitled to any "due process" rights when the beneficiary's compensation is reduced?

Yes. In addition to the answer in number two above, a FECA beneficiary whose compensation is reduced has additional ways in which to obtain review of that decision. Following a decision that either reduces or terminates a beneficiary's entitlement to compensation, he or she may request an oral or written review of such decision by an OWCP hearing representative. That the request must be made within 30 days of the decision reducing or terminating entitlement and before any request for reconsideration by the district office of OWCP (whether or not the request for reconsideration is granted). Claimants injured on or after July 4, 1966, have the right, under § 8124(b)(1) of the FECA, to request an informal hearing with respect to an entitlement decision "before a representative of the Secretary." While these hearings are held *after* the OWCP issues its decision reducing or terminating entitlement, they nonetheless meet the flexible standards of procedural due process set out in *Mathews v. Eldridge*, 424 U.S. 319 (1976).

Sections 10.615 through 10.622 of the current regulations describe the hearing process under the FECA. In particular, § 10.617 concerns oral hearings and states the following:

(a) The hearing representative retains complete discretion to set the time and place of the hearing, including the amount of time allotted for the hearing, considering the issues to be resolved.¹

(b) Unless otherwise directed in writing by the claimant, the hearing representative will mail a notice of the time and place of the oral hearing to the claimant and any representative at least 30 days before the scheduled date. The employer will also be mailed a notice at least 30 days before the scheduled date.

(c) The hearing is an informal process, and the hearing representative is not bound by common law or statutory rules of evidence, by technical or formal rules of procedure or by section 5 of the Administrative Procedure Act, but the hearing representative may conduct the hearing in such manner as to best ascertain the rights of the claimant. During the hearing process, the claimant may state his or her arguments and present new written evidence in support of the claim.

¹ The Department of Labor has 27 hearing representatives who make approximately 250 trips a year to upwards of 100 cities a year based on the volume of incoming hearing requests. OWCP schedules approximately 6,750 hearings per year. Every effort is made to schedule a hearing within 200 days of the claimant's request at a location no more than one hundred miles from the claimant's home.

(d) Testimony at oral hearings is recorded, then transcribed and placed in the record. Oral testimony shall be made under oath.

(e) OWCP will furnish a transcript of the oral hearing to the claimant and the employer, who have 20 days from the date it is sent to comment. Any comments received from the employer shall be sent to the claimant, who will be given an additional 20 days to comment from the date OWCP sends any agency comments.

(f) The hearing remains open for the submittal of additional evidence until 30 days after the hearing is held, unless the hearing representative, in his or her sole discretion, grants an extension. Only one such extension may be granted. A copy of the decision will be mailed to the claimant's last known address, to any representative, and to the employer.

(g) The hearing representative determines the conduct of the oral hearing and may terminate the hearing at any time he or she determines that all relevant evidence has been obtained, or because of misbehavior on the part of the claimant and/or representative at or near the place of the oral presentation.

(4) What are a beneficiary's "due process" rights if the OWCP determines that the beneficiary was overpaid and the OWCP makes a demand for reimbursement?

Before demanding reimbursement of an overpayment compensation benefit from a FECA beneficiary, OWCP provides both preliminary notice and an opportunity for a hearing. Consistent with the Supreme Court's decision in *Califano v. Yamasaki*, 442 U.S. 682 (1979), the OWCP's current regulations at §§ 10.430 through 10.441 provide for both preliminary notice and a "right of hearing" before any "demand for reimbursement" is made for an overpayment of compensation. In particular, § 10.431 states that:

Before seeking to recover an overpayment or adjust benefits, OWCP will advise the beneficiary in writing that:

(a) The overpayment exists, and the amount of overpayment;

(b) A preliminary finding shows either that the individual was or was not at fault in the creation of the overpayment;

(c) He or she has the right to inspect and copy Government records relating to the overpayment; and

(d) He or she has the right to present evidence which challenges the fact or amount of the overpayment, and/or challenges the preliminary finding that he or she was at fault in the creation of the overpayment. He or she may also request that recovery of the overpayment be waived.

Once the OWCP has issued the preliminary notice of an overpayment and finding of fault, § 10.432 provides that the beneficiary may “present evidence to OWCP in response to a preliminary notice of an overpayment,” either “in writing or at a pre-recoupment hearing,” as long as the evidence is “presented or the hearing requested within 30 days of the date of the written notice of overpayment.”

- (5) What are the OWCP’s guidelines with regard to deferring to the view of a treating physician? What weight does OWCP give to the physician’s view? Is the weight given by OWCP to the treating physician’s views consistent with the weight used by other federal agencies when determining eligibility for or level of benefits?**

The policy followed by OWCP and the ECAB in weighing the opinion of a treating physician is consistent with the approach taken by administrators of other benefit programs such as the Social Security Administration (SSA). The “attending [or treating] physician rule” is nothing more than a jurisprudential principle regarding the weight to be given to particular medical evidence. While the rule is, in fact, based in part upon the treating physician’s “continuing observation of the patient’s condition over a prolonged period of time,” the SSA, by regulation, gives controlling weight to the opinion of a treating physician only if it is “well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] record.” 20 C.F.R. § 404.1527(d)(2). See *Winford v. Chater*, 917 F. Supp. 398 (E.D. VA, 1996); *Shrewsbury v. Chater*, 1995 WL 592236 (4th Cir. 1995 (unpublished)); *Schisler v. Sullivan*, 3 F3d 563 (2d Cir. 1993).

The SSA regulations provide that if a treating physician’s opinion is not given controlling weight, a number of factors should be applied in determining the weight to give the opinion. In this context, the “rule” is simply guidance to be used by a fact-finder in weighing the evidence before him or her. See, for example, *Rosa v. Callahan*, 168 F.3d 72,78

(2d Cir. 1999) (“The opinion of a treating physician is given controlling weight if it is well supported by medical findings and not inconsistent with other substantial evidence.”); *Walters v. Commissioner of Social Security*, 127 F.2d 525, 530 (6th Cir. 1997) (where treating physician’s opinion is not conclusive as to the critical issue and is contrary to substantial evidence to the contrary in the record, the fact-finder “is not bound by the treating physician’s opinions”); *Books v. Chater*, 91 F. 3d 972, 979 (7th Cir. 1996) (“in the end, ‘it is up to the ALJ to decide which doctor to believe – the treating physician who has experience and knowledge of the case, but may be biased, or . . . the consulting physician, who may bring expertise and knowledge of similar cases – subject only to the requirement that the ALJ’s decision be supported by substantial evidence.’”); *Wilson v. Apfel*, 172 F.3d 539, 542 (8th Cir. 1999) (“Although a treating physician’s opinion is generally entitled to substantial weight, such opinion does not automatically control, since the record must be evaluated as a whole.”); *Morgan v. Commissioner of the Social Security Administration*, 169 F. 3d 595, 600-601 (9th Cir. 1998); *Reid v. Chater*, 71 F. 3d 372, 374 (10th Cir. 1995).

Even before the promulgation of the Social Security regulation, the opinion of a treating physician was not afforded controlling weight where the record demonstrated “good cause” for rejecting it. *Schister v. Heckler*, 787 F. 2d 76, 85 (2d Cir. 1986) (“a treating physician’s opinion on the subject of medical disability is binding on the factfinder unless contradicted by substantial evidence.”); *Schnorr v. Bowen*, 816 F.2d 578, 581-582 (11th Cir. 1987) (factfinder “properly discounted [treating physician’s] opinion that Schnorr was totally disabled because it was not supported by objective medical evidence and was merely conclusory”); *Floyd v. Bowen*, 833 F. 2d 529, 531 (5th Cir. 1987) (“unless good cause can be shown to the contrary, a treating physician’s opinion is entitled to considerable weight.”). The “treating physician rule” has similarly varied effect in proceedings under state worker’s compensation statutes. See, for example, *Goodman v. Pennsylvania Department of Public Welfare*, 695 A. 2d 945, 949 (PA, 1997); *EBI/ORION Group v. Blythe*, 957 P. 2d 1134, 1136 (MN, 1998) (“a treating physician’s opinion is not conclusive. To presume otherwise would quash the role of the fact finder in questions of an alleged injury.”); *Ross v. Remediation Services of Louisiana, et al.*, 714 So. 2d 218, 223 (LA, 1998) (despite the general jurisprudential rule that a treating physician’s opinion is entitled to added weight, “the trier of fact is not bound to accept the testimony of an expert whose testimony is presumptively given more weight if he finds the opinion is less credible than that of other experts.”)

The ECAB, in adjudicating FECA cases, has recognized that while the opinion of a treating physician might be accorded greater weight, it must still be evaluated and if it is not sufficiently explained, and is contrary to evidence that withstands similar scrutiny, will not be controlling. *Jack B. Schoff*, 1989 WL 222410 (E.C.A.B.). See also *Timothy E. Murray*, 1987 WL 91033 (E.C.A.B.) (treating physician report “of little probative value” where doctor did not describe method of calculation of impairment, did not mention A.M.A. Guides, and is indefinite and speculative in nature.). OWCP’s practice under the Federal Employees’ Compensation Act (FECA) also is fully consistent with the foregoing precedent. In all cases, a medical report is required from a claimant’s attending physician (20 C.F.R. 10.330), and in most cases, benefits are paid on the basis of such reports. When OWCP determines that a second opinion is warranted, or where additional medical reports are submitted by hospital or emergency facilities, all the medical evidence must be considered in adjudicating the claim. In weighing medical reports, OWCP claims examiners must consider a number of issues relevant to the probative value of the evidence. FECA Proc. Manual Part 2-0810-4.

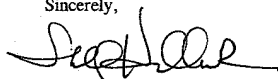
OWCP recognizes that the attending physician is the primary source of medical evidence in most cases and usually sees the claimant soon after the injury or onset of symptoms. The attending physician may also be familiar with the claimant’s medical history and know of preexisting conditions that should be considered. These factors do not outweigh the need for detailed information and a rationalized opinion, however, nor can familiarity with the claimant replace medical expertise. All such factors are properly considered in weighing the evidence with respect to a claim. OWCP’s Procedure Manual indicates that a “second opinion” physician’s opinion that differs from that of the attending physician with respect to critical issues will take precedence, but only where all other factors are equal and the attending physician is a general practitioner but the “second opinion” is provided by a Board-certified specialist in the appropriate specialty. This result is merely an application of the principle recognized in all the cases cited above – that where the fact finder has appropriate grounds for crediting one report over another, that finding should not be disturbed on appeal.

Nor is the special weight afforded the opinion of an impartial referee inconsistent with this principle. First, an impartial referee’s opinion is given additional weight because the examination by such a referee is required by the statute where there is a conflict in medical evidence of equal weight. 5 U.S.C. 8123(a); 20 C.F.R. § 10.502. A referee’s opinion is afforded this special weight, however, only if there is, in fact,

a conflict in the evidence (See *Jordan M. Carter*, 32 ECAB 856), and only if the referee's "conclusion is not vague, speculative or equivocal and is supported by substantial medical reasoning" (*James P. Roberts*, 31 ECAB 1010). See, FECA Procedure Manual (Part 2-0810-11(c)(2). Under these circumstances, affording some greater weight to an impartial referee's opinion, which is required by statute, which supports evidence already in the file and already determined to be equal to the weight of conflicting evidence, and which must be inherently definitive, well-rationalized, and supported by substantial reasoning, can hardly be said to be contrary to the "treating physician rule."

Thank you for the opportunity to provide additional information on this program which provides such important benefits to injured Federal workers.

Sincerely,

A handwritten signature in black ink, appearing to read "Shelby Hallmark", with a stylized flourish at the end.

Shelby Hallmark
Deputy Director

cc: The Honorable Stephen Horn

Mr. HORN. So Ms. Maggio, what would you like to add?

Ms. MAGGIO. I want to state that a lot of the other agencies have congressional offices that have a staff who handle congressional calls only.

And OWCP in Philadelphia, they have a congressional phone line to the District Director's office, but it's the claimant. There's not a special congressional staff to help. And I know that the claimant—or the claims examiners, they have a lot—you know, their workload is backed up. And for them to stop and explain something to us, just delays their work even further. So maybe as a possible suggestion for the congressional point, if there was a staff that we could communicate with, it might be more effective.

Mr. HORN. That's a good suggestion, I think for any agency, frankly.

We are now finished with this panel. And I think I will try to bring panel III forward, if they're present. Patricia Dalton, the Deputy Inspector General, Office of Inspector General, Department of Labor, will be accompanied by Amy Friedlander, Evaluations and Inspections.

And the second witness will be Shelby Hallmark, Deputy Director, Office of Workers' Compensation Programs, Department of Labor. And Shelby Hallmark will be accompanied by Sharon Tyler, District Director, San Francisco Regional Office.

Mr. HALLMARK. Chairman Horn, let the record show it's Mr., not Ms. here. My name does go both ways.

Mr. HORN. I left it open. Thank you. If there's any staff behind you that are also going to advise you, we can save a lot of time if they stand up too and you take the oath, even if you aren't going to do it. But it will save us from interrupting the hearing to give oaths every 5 minutes.

OK. Would you stand, raise your right hands, and those behind you.

Do you affirm that the testimony you're about to give this subcommittee is the truth, the whole truth, nothing but the truth.

[Witnesses affirmed.]

Mr. HORN. OK. I saw seven members, four at the table and three in the audience.

So let us start with Patricia Dalton, the Deputy Inspector General.

STATEMENTS OF PATRICIA DALTON, DEPUTY INSPECTOR GENERAL, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF LABOR, ACCOMPANIED BY AMY FRIEDLANDER, EVALUATIONS; AND SHELBY HALLMARK, DEPUTY DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, DEPARTMENT OF LABOR, ACCOMPANIED BY SHARON TYLER, DISTRICT DIRECTOR, SAN FRANCISCO REGIONAL OFFICE

Ms. DALTON. Good morning, Mr. Chairman. Thank you for inviting the Office of the Inspector General to discuss customer service issues within the Office of Workers' Compensation Programs at the Department of Labor.

Over the past two decades, the OIG has devoted significant resources to detecting and preventing fraud and abuse within the FECA program through our audits, investigations, and evaluations.

The OIG has conducted two recent evaluations of customer service-related issues within the FECA program.

The first evaluation examined two timeliness issues that arose during the July 1998 hearing held by this subcommittee.

[The prepared statement of Ms. Dalton follows:]



OFFICE OF INSPECTOR GENERAL

**Year 2000 Computer Compliance at the
U.S. Department of Labor**

**Witness appearing before the
House Committee on Education and the Workforce
Subcommittee on Oversight and Investigations
U.S. House of Representatives**

**Patricia A. Dalton
Deputy Inspector General**



**STATEMENT OF PATRICIA A. DALTON
DEPUTY INSPECTOR GENERAL
U.S. DEPARTMENT OF LABOR
BEFORE THE HOUSE COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON GOVERNMENT MANAGEMENT, INFORMATION,
AND TECHNOLOGY
U.S. HOUSE OF REPRESENTATIVES**

May 18, 1999

Good morning Mr. Chairman and members of the Subcommittee. Thank you for inviting the Office of the Inspector General (OIG) to discuss customer service issues within the Office of Workers' Compensation Programs (OWCP) at the U.S. Department of Labor (DOL). I am here in my capacity as Deputy Inspector General to present the views of the OIG, which may not necessarily be representative of those of the Department of Labor.

BACKGROUND

The U.S. Department of Labor administers several programs and statutes designed to provide and protect the benefits of workers and retirees, including the Federal Employees' Compensation Act (FECA) Program, the Longshore and Harbor Workers' Compensation Program, the Unemployment Insurance Program, and key provisions of the Employee Retirement Income Security Act. FECA is a major Federal benefit program that affects the budgets of all Federal agencies. This year, FECA costs are expected to total about \$2 billion.

FECA is a comprehensive workers' compensation law for Federal employees that is designed to provide coverage for work-related injuries or deaths to some 3 million Federal employees and postal workers. Benefits are paid from the Employees' Compensation Fund, which is administered by OWCP and principally funded through chargebacks to the employing agencies.

Over the last two decades, the OIG has devoted significant resources to detecting and preventing fraud and abuse within the FECA program through the OIG's program of audits, investigations, and evaluations. To date, the OIG's work has disclosed vulnerabilities that can often lead to inefficiencies and loss of Federal funds.

Most recently, the OIG has conducted two evaluations of customer service-related issues with the FECA program. The first examined two specific issues that arose during a July 1998 hearing held by this Subcommittee. The second OIG evaluation examined OWCP customer service surveys from 1995 through 1998.

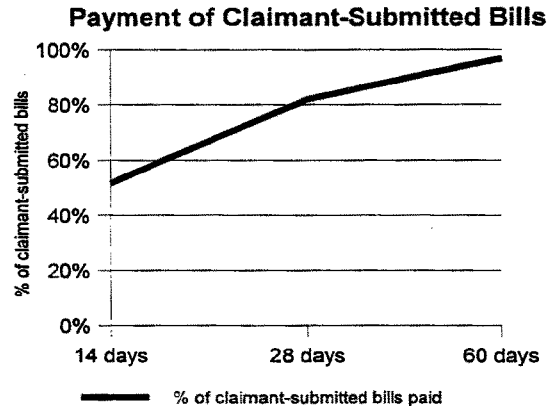
MEDICAL REIMBURSEMENTS AND SURGICAL AUTHORIZATIONS

Mr. Chairman, last summer, this Subcommittee held a hearing to investigate whether injured Federal employees receive timely and equitable adjudication of their compensation claims. At that hearing a number of witnesses testified about their concerns with the compensation claims process. Following the hearing, the OIG analyzed the hearing transcript and the allegations made by the claimants at the hearing. We also reviewed a relevant General Accounting Office (GAO) report. Based on this analysis, we examined two outstanding issues regarding whether OWCP was timely in responding to claimant requests for reimbursement for out-of-pocket medical expenses, and requests for surgical authorizations.

In examining the issue of claimant reimbursement for out-of-pocket medical expenses, we reviewed existing OWCP data, which revealed that reimbursements to claimants represent only 3 percent of all medical bills. The remaining 97 percent of the claims are submitted by medical providers and health plans.

In addition, we reviewed the reimbursement standards that OWCP has established. These standards for claimant reimbursement have been established at the 28-day level and the 60-day level. OWCP's own data showed that the agency falls slightly short of meeting its 90 percent standard for the 28 day period, paying 82.1 percent of all claimant-submitted bills within the 28 days. At the 60-day standard, OWCP has paid 96.9 percent of all claimant-submitted bills. In addition, OWCP has recently

implemented an automated bill review system. Prior to the new system, OWCP had to manually review each bill. OWCP has indicated to the OIG that it expects this new system will shorten the processing time for bills and, therefore, increase the percentage of claimant-submitted bills paid within the time frames.



Pharmacy bills are the single largest cost category of claimant-submitted reimbursements. Our review found that OWCP was able to pay 97 percent of claimant-submitted pharmacy bills within 60 days, and 83 percent of these claims were paid within 28 days. This past July, OWCP implemented an electronic billing system that enables pharmacies to bill OWCP directly, eliminating the need for claimant out-of-pocket expenses. OWCP records indicate that after only four months, the new system has reduced claimant-submitted pharmacy bills by 10 percentage points.

The second issue that arose from the July 6, 1998, hearing was concerns about the timeliness of surgical authorizations. In this area, OWCP deals with two different types of surgeries: emergency and non-emergency. If an employee suffers a traumatic injury at work and requires emergency surgery, the employing agency is responsible for authorizing the medical treatment within four hours of injury. Our review examined OWCP's handling of requests for non-emergency surgery.

While OWCP has no automated system to track the time between requests for non-emergency surgery and authorizations by OWCP, some OWCP district offices

attempt to manually track this information. For example, the New York District Office has dedicated a fax line to receive medical authorization requests. The goal is to respond to claimants within one week, whenever possible. Although OWCP indicates that claims examiners are working to expeditiously process surgical authorizations, we could not identify a standard within OWCP, or within the industry, to benchmark performance.

We contacted many different sources, including the Workers' Compensation Research Institute and State Workers' Compensation Programs, but could not find a standard to measure OWCP's performance. Although the overall range for processing authorization requests was 0 to 354 days, ninety-three percent of the cases fell within the range of 0 to 85 days. Leaving the five atypical cases (354, 326, 225, 124, and 102 days) out of our calculations, we found that on average, OWCP processed surgical requests in 26 days, with the median (mid-point) being 17 days and the mode (most frequent value), which occurred 5 times, 7 days. The range shows what program officials told us -- that the time it takes OWCP to process a surgical request varies greatly depending on the case. Although we did not find a pattern of delays in the case files we examined, our report recommends that OWCP establish a performance standard for responding to requests for surgical authorizations in order to reduce claimant uncertainty about the process.

OWCP CUSTOMER SERVICE SURVEYS

Mr. Chairman, our second evaluation reviewed OWCP's customer service surveys from 1995 through 1998. We conducted this review in order to determine whether OWCP's surveys are a useful tool in providing information about customer service.

Earlier OIG and GAO reports found no evidence of anti-claimant bias on the part of OWCP. However, our first review of reimbursement for out-of-pocket medical expenses and requests for surgical authorizations, alerted us to possible problems with OWCP customer service. A preliminary review of OWCP's customer service surveys and interviews with agency officials indicated methodological deficiencies that raised concerns about the surveys' ability to provide useful information to the agency.

Because OWCP has conducted customer service surveys of claimants covered under FECA since 1995, we reviewed their last four survey reports and questionnaires and interviewed OWCP officials to analyze the methodology of the survey questionnaires. Our review identified deficiencies in the methodology used to measure customer service, as well as deficiencies in sampling, survey design, response rate, and survey operations. Although OWCP has made efforts to improve the surveys each year, our analysis revealed the existence of methodological flaws that cast doubt on the

accuracy of the information obtained from them. Our review identified the following problems:

- In terms of the survey design, we found that the 27-question, 4-page survey is too long, which may encourage respondents to rush or skip items. In addition, the changing formats within the questionnaire increased the difficulty in responding to questions.
- With regard to measuring customer service, we believe that to accurately report on a broad, multi-faceted topic across five different subgroups requires using more than just one questionnaire. We have recommended that OWCP consider other methods of measuring customer service, including using focus groups with representatives of different claimant groups and using existing agency data sources, such as telephone logs or correspondence tracking. Focus groups are particularly useful for exploring issues and can contribute a clear understanding of customer needs.
- In terms of the sampling methodology, we found that some of the five sample groups are over-sampled, while others are under-sampled. For example, approximately equal samples were drawn from dissimilarly-sized groups. One group was comprised of 154,000 claimants who had not lost time from work, and a second group with only 24,000 claimants who had been denied a claim. Sampling an equal number from these two sub-groups (and the three others) does not ensure that all claimants have an equal chance of selection in the overall sample. Consequently, this may potentially skew OWCP's sample.
- In one year's survey, we found that the questions asked in the questionnaire did not specifically pertain to the sample that OWCP drew. Consequently, many respondents may have believed that the survey did not apply to them.
- Our review also found that OWCP does not retain any data from the surveys. Because of potentially incomplete records, the data and research conducted cannot be verified. Moreover, valuable information, as well as the opportunity for subsequent research with the data sets, is lost.
- Although the response rate is improving, it remains considerably below the OMB standard of 80%. However, in 1998, OWCP did conduct a telephone survey to identify the characteristics of non-respondents to verify the quality of the responses they obtained.

Unfortunately, Mr. Chairman, the many problems associated with the research methodology make it very difficult to assess the adequacy of the annual survey.

Ultimately, OWCP is unable to fully discern whether Federal injured workers are being adequately served by the process intended to help them. In order to make the survey accurate and useful, and to better understand the concerns of injured workers, our recommendations have been crafted to ensure that OWCP will be able to collect high-quality data for performance planning and managing customer service to Federal claimants. OWCP generally concurred with our findings and management has indicated that they will be using most of our recommendations to improve future customer service surveys.

CONCLUSION

Since the Subcommittee reviewed these issues last July, the issue of customer satisfaction within OWCP has been reviewed in a number of different ways. Despite the problems associated with the way OWCP surveys its customers, the OIG believes that OWCP has the ability to make the necessary corrections to allow for a more useful survey. These changes, if implemented, will enable OWCP to have a better strategic planning process, and -- more importantly -- help them obtain a better gauge of the concerns that injured Federal workers have with the current process. Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions that you or the other Subcommittee Members may have.

Ms. DALTON. The second evaluation examined OWCP customer-service surveys from 1995 through 1998.

Following this subcommittee's field hearing last summer, the OIG reviewed the hearing transcript and the allegations made by a number of claimants.

Specifically, we focused on two outstanding issues. The first issue is the timeliness of OWCP in responding to claimant requests for reimbursement of their out-of-pocket medical expenses.

In examining the issue of claimant reimbursement for out-of-pocket medical expenses, we found that reimbursements to claimants represent only 3 percent of all medical bills. OWCP has established standards for claimant reimbursements at the 28-day level and the 60-day level.

At 82 percent, OWCP's own data shows that the agency fails short of meeting its 90 percent standard for the 28-day period.

However, it does exceed its 60-day standard of 95 percent by paying 96.9 percent of all claimant's submitted bills within 60 days. Recently OWCP implemented an automated bill-review system which they expect will further shorten the bill processing time.

The second issue that arose from the July 1998 hearing concerns were concerns about the timeliness of surgical authorizations. Our review focused on OWCP's handling of requests for nonemergency surgery since emergency surgery is authorized by the employing agency.

Our review disclosed that OWCP has now an automated system to track the time between requests for nonemergency surgery and authorizations by OWCP. Although some OWCP district offices are attempting to manually track this information.

While OWCP indicates the claims examiners are working to expeditiously process surgical authorizations, we could not identify an OWCP or industry standard that is used to benchmark performance. To help improve the system, our report recommends that a performance standard be established for responding to non-emergency surgical requests. We believe that this would help to reduce claimant uncertainty about the process.

We conducted a second evaluation where we examined OWCP's customer-satisfaction surveys from 1995 through 1998 to determine whether those surveys are useful tools in assessing customer satisfaction.

Our review of the four survey reports identified a number of problems. We found that the 27-question 4-page survey was too long and difficult to complete. We recommended that OWCP supplement the survey with focus group data which can contribute to a more detailed understanding of customer service and concerns.

We found that some of the five sample groups were over sampled while others were undersampled. Sampling of a virtually equal number from these groups does not reflect the proportional difference in the national claimant population.

We found that the questions asked in 1-year surveys—survey did not specifically pertain to the sample that OWCP drew. Consequently, many respondents may not have returned the surveys assuming that it did not apply to them.

Finally, we also found that OWCP does not retain any data from the surveys, thereby precluding its verification and the opportunity for subsequent research.

As a result of the problems with the survey methodology, OWCP is unable to fully discern whether Federal injured workers are being adequately served by the process intended to help them. In order for the survey to be useful to OWCP and better understand the concerns of injured workers, we made a number of recommendations to help OWCP in the collection of high quality data for performance planning and managing customer service to Federal claimants.

Despite the problems associated with the way OWCP surveys its customers, the OIG believes that OWCP has the ability to make the necessary corrections to allow for a more useful customer satisfaction survey. These changes, if implemented, will enable OWCP to have a better strategic planning process and, more importantly, help the agency to better gauge and address the concerns that injured Federal workers have with the current process.

OWCP has indicated in their response to the evaluation—to our evaluation report the intent to make a number of changes in their survey process.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions that you have.

Mr. HORN. We'll hear from the administration then if you can stay with us, we'll have a dialog here.

Mr. Shelby Hallmark is the Deputy Director for the Office of Workers' Compensation Programs and the Employment Standards Administration of the U.S. Department of Labor.

Welcome. A number of people, I think, over you were either out of town or something is what I'm told. So you're holding the whole burden. Please proceed.

Mr. HALLMARK. Thank you, Mr. Chairman, for the opportunity to come in to discuss the administration of the FECA program here today.

As you say, I'm the Deputy Director of OWCP which is the oversight, the umbrella organization, one of our programs is the FECA program.

I have with me today Ms. Sharon Tyler who is the District Director in our San Francisco Regional Office and the largest of the FECA offices. She's currently acting as the Acting Deputy Director for FECA here in the National office.

I believe it would be helpful to review how OWCP's strategic plan and Government Performance and Results Act goals relate to this whole issue of customer service that we've been hearing about today and will undoubtedly continue to discuss. I think that provides a framework for what the organization is trying to do. And I would like to talk a little bit about that this morning.

Obviously my written testimony is longer, and I would refer folks to that for more detail.

Mr. HORN. Well, take your time. I want to give fairness to the administration. So take your time. We're in no hurry.

Mr. HALLMARK. I appreciate that.

Just a general word about the volume of our work. I think that's an important context to consider. I believe one of the previous wit-

nesses indicated the degree to which claims examiners are hard-working and, oftentimes, the issues that are raised in this kind of context are difficult.

OWCP gets roughly 8 million telephone calls and pieces of mail each year. With our 950 employees, that factors out to almost 9,000 contacts per each and every individual in this program.

We serve roughly 250,000 injured workers, injured Federal workers—

Mr. HORN. Let me ask at that point just to make sure the record is clear, you're saying they have 8 or 9,000 calls per employee?

Mr. HALLMARK. Per year.

Mr. HORN. Per year. Now, is that based on the voice mail where somebody might have called 10 times trying to reach a human being? What kind of data—

Mr. HALLMARK. The 8 million figure represents roughly 2½ million telephone calls, which is our estimation.

We don't have an exact number. It's an approximation based on our telephone systems that provide reports in some cases. We try to delete from that duplicates of the kind that you're suggesting. The other 5½ million items are pieces of mail, medical bills, and so on.

Mr. HORN. Let me ask the Inspector General, have you ever checked the telephone numbers?

Ms. DALTON. No, we haven't, Mr. Chairman.

Mr. HORN. Would you take a look at it, and let us know. Thank you.

Go ahead, Mr. Hallmark.

Mr. HALLMARK. Yes, sir.

We serve, as I was saying, about 250,000 injured Federal workers in any given year. We pay roughly \$2 billion in benefits each year and 96 percent of the cost of this program is delivered to injured workers and their medical providers which makes the FECA program perhaps the leanest compensation system in the country in terms of administrative costs.

Most of the injuries of that 250,000 that I'm describing are minor ones. And OWCP basically is involved only in making medical payments for those individuals.

The major source of difficulty, some of which we've heard about this morning, in those cases—and there are roughly 150,000 of them each year—comes into play when the Federal agency, the employing agency, fails to send the notice of injury to OWCP timely. If we have no official notice, we cannot make a payment. The individual who is from a doctor's facility was reflecting the difficulties that occur when that happens.

When we do have a case established, we make payments on medical bills. And, as I say, we receive millions of them, and about 90 percent of the time, we pay within 28 days. Roughly 95 percent of the time, as Ms. Dalton was indicating, within 60 days.

About 50,000 workers are on long-term monthly wage-loss replacement benefits from OWCP. For them, we have a much more intense involvement. We serve as their payroll office as well as dealing with medical issues and other assistive services.

A smaller group of individuals receive wage-loss benefits from us on a part-time basis or interim basis during the year, and then, in

most cases, return to work. And a smaller group still each year, approximately 18,000 cases, are denied. And, obviously, in those cases many of the difficulties that some of the previous panels have talked about can occur where there are obvious differences of opinion regarding the nature of the case.

A little history would be helpful, I think, in evaluating the FECA program. We fell behind dramatically in the 1970's in this program in handling the basic workload, getting cases adjudicated and making payments. During the 1980's, we instituted a number of initiatives to get a handle on that workload.

We established numerous performance measures and standards to provide a target, and we held our staff accountable for accomplishing those timeframes. As a result of that, since the mid-to late 1980's, we have been able to adjudicate our cases as they come in the door relatively promptly, and we believe the great majority of cases are, in fact, expeditiously handled.

Roughly 90 percent of all cases coming in the door are approved. When the GAO and the OIG have audited our programs, they have uniformly found that our processes are basically fair and reasonable.

However, we recognized at the close of the 1980's that there were a number of continuing problems in this program. And the strategic plan that I'm about to describe to you which has evolved as now being a part of the Government Performance and Results Act effort, basically was developed to address how this program can transform itself to address the major issues that we saw.

And those issues really were three major components. One, customers were frustrated with our ability to communicate with them effectively; two, we found that the individuals on our long-term rolls were often staying on the long-term rolls even when it appeared that their injury was not totally disabling; and, three, the costs of the program were escalating.

Analyzing those issues, as I said, we chose to try to transform this program, and our strategic plan basically amounts to a transformation plan.

The plan basically has four elements. One is return to work, making injured workers whole by aiding them in getting back to the work place. We have found that throughout the world the benefit and importance to society, to the individual, to the family, of individuals being a productive member of society is key.

Two, improving overall customer service. Clearly that's the topic of our conversation most directly today.

Three, enhancing fiscal integrity.

And, four, enhancing agency and union partnerships throughout the Federal Government to accomplish all of the above goals.

That strategic plan was, by the way, established as the partnership activity within our own Department of Labor family.

We believe we've made important strides. And my written testimony addresses the accomplishments of the organization in terms of those specific measures that are identified in our GPRA plan including return-to-work measures, cost-containment measures, and customer-service measures.

But clearly the customer-service component of our plan is the most challenging aspect for this program to achieve. We have made

progress. All three of the measures that we report on for customer service are showing steady improvement, but we're not satisfied with those improvements. And clearly we will continue to make enhanced efforts.

Customer service is, by definition, a labor intensive and very expensive undertaking. And shifting our staff's central concern or view of what they do in their job from being an adjudication and paper-processing operation to being an interactive, dynamic, service-providing operation is a long-term undertaking. We believe it will take time, it will take improved tools, and it will take training. We know we have a long way to go, and we're working hard to get there.

I cite a few examples of what we're doing. Let me just give you a few of the things that are in my written testimony. First, we've gotten more staff. In 1999, we received a 10 percent increase in staff which had been sought for a number of years. It takes more people to be more responsive in a program like this. And even with that 10 percent increase, OWCP has among the highest per FTE caseloads of any program of this kind.

I mentioned earlier that we get about 8,000, 9,000 calls and letters per person. A 10 percent increase in staff amounts to an 800 or 900 per person per year reduction, and that's not small.

That will have a major impact on the ability of this program to meet the needs of the individuals we heard today and all the other individuals who come to us seeking services.

[The prepared statement of Mr. Hallmark follows:]

**Statement of Shelby Hallmark, Deputy Director
The Office of Workers' Compensation Programs
Employment Standards Administration
U. S. Department of Labor
Before the Subcommittee on Government Management, Information and
Technology, House Government Reform Committee
May 18, 1999**

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today and appreciate this opportunity to discuss the administration of the Federal Employees' Compensation Act (FECA) by the Department of Labor's Office of Workers' Compensation Programs (OWCP), and to address some of the important issues and concerns people have about this program.

The Federal Employees' Compensation (FEC) program covers nearly three million Federal employees in 72 different agencies, providing benefits to any of them who sustains an injury or illness in the performance of duty anywhere in the world. Because of the extreme importance of this protection to Federal workers, OWCP tries to provide those benefits when they are due as quickly as possible, and OWCP offers the full range of medical and rehabilitation services to return injured employees to productive work at the earliest date possible. For the 170,000 injury notices filed annually, we maintain high standards of decision timeliness and prompt payment of wage loss claims and medical bills, and are especially proud of the high number of workers successfully returned to work. At the same time we recognize our fiduciary responsibility to Federal employers and taxpayers. Since 1993 our periodic roll management project and other cost containment efforts have saved hundreds of millions of dollars and reduced the overall cost of the program measured in constant dollars.

OWCP's record of timely adjudication, well-controlled inventories, and timely payment has been consistent since the mid-eighties, when, after an intensive effort including ongoing automation initiatives, the program slowly gained control of a dramatically increased workload which overwhelmed our administrative resources in the late 1970's. Beginning in 1992, and well before the Government Performance and Results Act made strategic planning a requirement, OWCP turned its attention to achieving positive outcomes for employers and employees through careful deployment of its limited resources. Our administrative expenditures have remained extremely low compared to most comparable state compensation programs, about 4 percent of total costs. Nevertheless, in the last several years we have been able to target and achieve better outcomes for employees, in the form of early and safe return to work, in addition to prompt provision of benefits when due; and for employers, in terms of better control of disability and medical costs.

OWCP has taken the mandates of the Government Performance and Results Act extremely seriously, and we believe that the goals and measures we have established in carrying out the GPRA will help us achieve increasingly positive outcomes in the future. The key measures we are holding ourselves accountable for this year and through FY 2002 under our current strategic plan are identified in Appendix A. As that document shows, OWCP is meeting or on schedule to

meet all of our FY 1999 goals for the FEC program, and we believe that record reflects the genuine progress -- and improvements in real-world results -- for our customers and stakeholders.

Our strategic goal number one is to return injured employees to work as soon as medically appropriate. The measure of our success in this area is a reduction of lost production days due to work-related injuries. OWCP has achieved more than a 9 percent reduction in this measure through the first half of FY 1999.

Our second goal is improved service to injured workers. The three GPRA measures for this goal -- customer satisfaction, employing agency timeliness of claims submission, and quality of case work -- have all improved steadily since we began our measurements. These improvements are in addition to the continuing strong performance of the program in terms of timely adjudication and payment of wage-loss and medical benefits, which is the fundamental aspect of good customer service in a benefit program. In addition, we have accomplished improved timeliness in response to telephone and written inquiries.

The third goal is fiscal integrity, and all three measures -- savings via the Periodic Roll Management project, savings in the medical bill payment arena, and implementation of electronic ("paperless") processes -- are being met or will be met by the end of the year.

The final strategic goal is to enhance our relationships with customers and stakeholders -- including especially the employing agencies and employee unions. While this goal does not lend itself as readily to quantitative measurement, we are pursuing cooperative efforts on a wide range of issues with our partners, and we believe these efforts will pay continuing dividends in terms of improved overall service to the ultimate beneficiaries of the program -- injured Federal workers.

Despite this strong evidence of real performance improvement in the FEC program, we are aware that much remains to be done. The results just described are hard-won, given the limitations on our administrative budget, the unrelenting volume of the work, and its inherent complexity. Although all of our goals are challenging, providing first class customer service and achieving broad customer satisfaction are perhaps the most difficult. We recognize that many injured workers and others who are engaged by this program have serious concerns, and as we indicated at the hearing in July 1998 in Long Beach, we appreciate the Subcommittee's raising some of these issues to our attention.

Any discussion about customer service in the context of the FEC program must take into account the distinguishing characteristics of the program, and should consider the entire (voluminous) population of injured workers and others whose needs must be addressed.

FECA's Characteristics

One distinguishing feature of this program is its legal focus. Entitlement to benefits does not flow just from the status of the individual claiming benefits, as it may when a veteran claims a service-connected disability, nor from time in service, as it may when a Federal employee applies for retirement benefits.

Rather, entitlement to workers' compensation benefits rests on a host of factors defined in the law and the regulations, including whether the claim was filed within the time limitations required by law, whether the person claiming benefits is in fact a Federal employee, and whether the employee was performing his or her official duties when the injury occurred. The first two of these determinations are usually straightforward, but the third can become very complicated, especially in claims for occupational illness.

A second distinguishing feature of this program is its basis in initial and continuing medical evaluation. Initially, medical evidence is used to determine whether a condition is in fact work-related. In complex and long-term cases, OWCP needs to re-evaluate the medical evidence from time to time to ensure that benefits continue to be paid at the correct level. While not unique to workers' compensation claims, this differs from the evaluation process in other programs, where a one-time medical assessment may be all that is needed to support payment of benefits at a constant level for a very long time.

This dual emphasis on legal decision-making and on the need for continuing medical evaluation informs many aspects of our program, and it helps to explain why the program often seems complicated to outside observers. This complexity makes the job of serving our customers all the more difficult as Americans have come to expect a greater degree of information about products they buy and services they receive. Meanwhile, OWCP has juggled increasing requirements for customer responsiveness with a large and unrelenting workload.

FEC Program's Workload

The program covers about three million civilian Federal employees, as well as members of a number of ancillary groups such as the Peace Corps, the ROTC, and non-Federal law enforcement officers. The program does not, however, cover active-duty members of the U.S. Armed Services. A review of some basic figures may help to convey the size of the program and its challenges.

In FY 1998 the program's 12 district offices received and processed 165,814 new injury or illness cases. Another 18,560 claimants filed new claims for wage loss.

The offices also maintained another 50,105 ongoing claims on the periodic roll for continuing partial or total disability. For these individuals, OWCP serves as a payroll operation, handling all manner of issues such as health benefit coverage, group life insurance and optional life

insurance, and open season changes, as well as continuing medical, rehabilitation and related services and support. In the first half of FY 1999 the program's offices processed 934,730 medical bills.

Each year, the program as a whole receives approximately 5.5 million pieces of mail; the offices receive almost 106,000 pieces of mail per week. Each year, the program as a whole also receives more than 2.6 million phone calls. On a weekly basis, over 40,000 calls are received and responded to program-wide. The offices receive and respond to more than 21,000 phone calls and letters from Congressional offices each year.

With less than a thousand employees to do the job, handling this massive, unrelenting workload is a daunting task, and our claims staff deserves recognition for the hard work they do every day in support of their fellow Federal employees. Largely because of the dedication of its staff, OWCP accomplishes its mission on an administrative budget that is extremely low as a percentage of the total cost of the program. On a per FTE basis, FEC employees are responsible for a significantly higher number of covered employees, number of claims, and benefit dollar outlays than their counterparts in comparable state workers' compensation programs.

The Definition of "Customer Service" in the FECA Context

The service that OWCP provides to claimants should be viewed in the context of the agency's role in administering the FECA. OWCP's role is to be the neutral adjudicator of claims against the various Federal agencies in their capacity as employers. OWCP must make a legal entitlement decision based on facts and medical evidence, as an adjudicating body, as well as acting in the role of an insurance company, as payer of benefits and provider of other services. The program's customer service goals are to render fair and accurate decisions on benefits, including treatment authorizations, and explain the decisions clearly and tactfully, to provide full appeal rights and assist people in obtaining these rights, and to give people full, accurate and timely information on their claims.

Customer Service Initiatives

The Subcommittee has indicated special interest in customer service, the area covered by the FEC program's second and fourth strategic goals. Although the Department of Labor's Office of Inspector General has recently provided us with a study citing the need for improvements in our customer survey methodology, OWCP believes that survey provides some useful information about customer attitudes, which comports with our experience in general regarding the claimant population. With the assistance of the OIG we anticipate obtaining more accurate information via this or alternative instruments in the future. The information available to date shows improvement over the past several years, but the general level of satisfaction reported (56 percent in the FY 1998 survey) is far from satisfactory.

Given the nature of our customer relationships, we know not everyone is going to be pleased with our services. But OWCP is committed to identifying and correcting service deficiencies, and we have been pursuing a wide range of initiatives in that regard. In addition to the strategies identified in our strategic plan, these include:

Additional staff. In FY 1999, the FEC program received nearly a 10 percent increase in staff, a much needed infusion of human resources which are absolutely critical to achieving quality customer service.

Extensive computer improvements. OWCP is making sweeping enhancements to its already sophisticated computer systems, which will increasingly allow electronic rather than paper communications, speeding transactions and improving our ability to track and control the information needed to process these cases. By FY 2000 all new cases will be scanned and processed as electronic documents, and by FY 2001 we expect to be in a fully paperless environment. We have already instituted a secure Internet system that provides employing agency staff with real-time access to virtually all the information they need to assist us in assuring the smooth operation of the system, and we are close to instituting electronic submission of claim forms from the agencies. Interactive Voice Response (IVR) telephone systems allow automated access to FECA payment status data for claimants and medical providers. Finally, we are completely redesigning the ADP support system that claims staff use to process cases, and the new system -- targeted for FY 2001 -- will greatly improve their ability to respond efficiently and effectively to the particular cases that need action on any given day.

Training. OWCP's FY 2000 budget request includes funding for the first nationwide training program for all FEC staff. This will address program fundamentals and familiarization with the major automation improvements just discussed, and is necessary to the success of the automation and imaging projects. It will also provide techniques for providing quality telephone and written communication, dealing with difficult customers, and developing other customer service skills.

Improved agency timeliness of claims submission. OWCP has worked with Federal agencies to significantly improve the speed of initial claims timeliness, a key element in ensuring that medical bills filed soon after the injury are paid timely and without the need for resubmission by the provider. Electronic submission and other efforts to speed this process will have an important effect in getting the vast majority of claims off to a good start.

Improved casework quality. FEC is focused on getting decisions right in the first instance, so as to avoid over burdening the appeals process with cases where appeals should not have been necessary.

Maintenance of basic claims processing and payment timeliness. No amount of responsiveness will improve satisfaction if adjudication and payment actions are not completed as promptly as possible.

Actions Since the July 1998 Subcommittee Hearing

In addition to the ongoing initiatives just discussed, OWCP has taken several measures that address the customer service and related concerns that were identified by Chairman Horn during the July 1998 hearing in Long Beach.

Hearings and Review

Of particular concern at that hearing was the delay experienced by injured workers who request an oral hearing appeal before the FEC Branch of Hearings and Review. Several improvements have been targeted in that area, including the speeding of the "front-end" review process that determines whether the case is in posture for a hearing or if it should be returned to the district office for action. This process has been expedited, and all such reviews are now completed within 30 days of the case arriving at the Branch.

More generally, the overall time from receipt of the appeal to delivery of a decision following a hearing has been reduced, from 312 days in September 1998, to 251 days in April 1999, and the number of cases awaiting a decision in the Branch has been reduced from 4805 in July 1998 to 4169 in April 1999, a 13 percent reduction. While we hope to make still further improvements, these data reflect significant progress in delivering timely decisions. Goals for improvement in both of these areas have been incorporated in the performance agreement for the Director of the FEC program.

Medical Authorizations

In October of 1998, national program managers began requiring each Regional Director to establish a method of identifying, tracking and measuring requests for medical authorizations received by telephone. This step was taken to ensure that employees and medical providers receive prompt, substantive responses to such requests. The methods vary by region, but many district offices use a report based on automated records of telephone calls, which have a category for medical authorization.

The tracking methodology was in place by January 31, and the first reports on the percentages of requests answered substantively have been received.

--While these reports are still being analyzed, preliminary results show that most offices are providing over 90 percent of their responses within three days or less.

--We are now going to look into the quality of subsequent responses, to ensure that cases where additional work is required to adjudicate the request are handled promptly and substantively as well, and to evaluate whether the most complicated requests need to be tracked separately. By the end of this fiscal year, we will have sufficient information to determine

whether a new performance standard is needed in this regard, and what the standard should be, in conformance with GPRA principles.

Through management reviews and accountability reviews, all offices are reviewing this issue as it relates to timeliness and quality of decisions.

For example, the New York District Office has a dedicated fax line to receive medical authorizations. The availability of the fax line is publicized through its Telephone Bank voice mail message system. When employees, medical providers or agencies contact any district office staff, they are advised to use this fax number to request authorizations for surgery and other medical requests. If a second opinion must be obtained to act on a surgery request, the examination is scheduled on a priority basis.

Second Opinion and Referee Specialists

At the last hearing, Congressman Davis noted the concerns of certain claimants who had attended a second opinion and referee medical examination at the direction of OWCP. These employees believed that the physicians did not grant them the time and attention necessary to obtain a true picture of their respective conditions, and contended that as a result the medical reports of these evaluations were seriously flawed.

As I noted in the beginning of this statement, the program depends on thorough and professional medical evaluations. We have procedures in place to review the performance of second opinion and IME physicians to assure that quality work is obtained. Following last year's hearing, we have required each regional director to ensure that this review mechanism explicitly includes identification and follow up on employee complaints of this kind.

Following Up with Employing Agencies

Many injured workers express concern about their Federal employers' handling of their FECA claims. These problems include untimely submission of forms and information to OWCP, non-availability of light-duty positions, lack of technical information about the claims process, in addition to underlying employee/employer disputes. As in the area of second opinion evaluations, the Regional Directors' performance agreements were modified to require that they establish systems to capture information about agency activities that may violate FECA regulations, procedures, or sound case management, and to provide effective feedback to agencies about the need to correct such practices.

Partnering with employing agencies and employee unions to enhance the overall delivery of FECA services is our fourth major strategic goal. To that end, OWCP has a multi-faceted program to work with agencies to manage their overall workers' compensation programs, implemented through discussions at the program head level with agency heads, national and local technical assistance meetings, seminars and workshops, and our various publications. During FY

1999 we have redoubled our efforts in this regard. Beginning this year, OWCP and OSHA will jointly pursue a government-wide "Federal Worker 2000" program which requires agencies to:

- Reduce the injury case rates for most Federal agencies by 3 percent per year, while at the same time increasing the timeliness of reporting new injuries and illnesses to OWCP for each agency by 5 percent per year.

- Reduce the lost time injury case rates for those worksites with the highest Federal lost time case rates by 10 percent per year.

- Following establishment of a baseline in FY 1999 or 2000, reduce the lost production days rate (lost days due to injury or illness per 100 employees) by 2 percent per year.

As part of this program, OWCP will measure all lost time, including the Continuation of Pay (COP) days paid by each agency in traumatic injury cases, and not merely wage loss periods. This will require that we find ways to assist return to work much earlier in the history of the injury, which studies have shown is more effective in preventing long-term disability.

For the last two years, OWCP has made the timeliness with which agencies submit injury notices and claim forms a central concern, using whatever forum is available to tell agencies that good case management and program management begin with this simple step. Agency performance, including establishment or bureau level data, is tracked and posted on OWCP's internet website.

Overall agency performance in this area has improved since we have been emphasizing it, but we have a long way to go. In this and other areas, OWCP has directed special attention to several large agencies, including the VA, Treasury, USPS and DOD, to address particular problems. Injury Compensation Specialists are being trained in the program's new regulations, and in many offices. Senior Claims Examiners (CEs) and Supervisory CE's have been matched with employing agencies to address problems arising with individual claims and to improve coordination between OWCP and the agencies.

New Regulations

OWCP recently revised in their entirety the regulations which govern administration of the FECA. These regulations became effective January 4, 1999. They are written in a question-and-answer format in a manner that is much more accessible for the lay person, which will allow them to be more readily used by injured workers and their representatives as a handbook for pursuing their claims. OWCP made a number of substantive changes to the regulations, among them the simplification of the process used to approve attorney fee applications. Before the revision, claims examiners were required to review each fee application for a number of factors, including time, cost, reasonableness and impact of the services on the outcome of the claim. Under the new regulations, if the claimant does not disagree with the attorney's fee request, as properly presented to OWCP, it can be approved immediately.

Recent ADP Improvements

The program continues to modify and enhance its ADP operations to address customer issues.

--The program's new regulations, effective January 4, 1999, included a provision for electronic payment of prescription bills, which will reduce the burden of injured workers by reducing the need for them to seek reimbursement for out of pocket expenses (since more and more pharmacies will bill OWCP directly given the electronic mode);

--The Interactive Voice Response (IVR) System has been updated, so that authorized persons can find out if a medical bill has been paid;

--The program's Internet site has been upgraded to make additional claims forms available to employees and employers.

What Remains To Be Done

OWCP continues to develop new strategies to tackle the issues we've been discussing today. As I've noted, improving customer service in a program like FECA is an expensive, labor-intensive undertaking, and most strategies for the future will require additional staff as well as equipment. Here are some of the approaches we are planning for the future.

The program's ability to respond to the millions of telephone calls we receive would be enhanced if we can improve our telephone equipment base and the link between our phone systems in each office and the FEC database. A fairly rudimentary system is in place now -- the IVR arrangement which permits a claimant or medical provider to key in identifiers and obtain automated payment information over the phone. We hope to expand on that capability, but to do so will require the installation of modern telephone switching devices in each office. We are investigating how best to address this need, in coordination with the Department of Labor's overall administrative arm.

OWCP has identified the potential benefit of installing a nationwide 800 number that injured workers, providers, and others could use to obtain quick information about the program, and possibly to speed the process of medical authorization. This would provide the public with an avenue for reaching a "live person" without diverting district office staff from their claims processing and management work. Competing demands on our scarce staffing resources, as well as limitations on our data systems, have made this approach impractical to date. However, we plan to move to a fully electronic system by FY 2001, which would permit nurses stationed at a central location to instantly access all medical reports on file for a case and make consistent and informed authorization decisions. The feasibility of this approach will be reconsidered in that context, again in conjunction with Department-wide initiatives.

OWCP is working with the OIG to improve its ability to measure customer satisfaction and identify means of improving service. Since a large part of the current frustration centers around our telephone responsiveness, we are considering whether a new design for assessing customer satisfaction with individual calls may be needed. In addition, a FECA partnership team is currently evaluating the performance standards and workload expectations of claims staff. This team has identified measurement of communications timeliness and quality -- a performance standard for claims staff in every office -- as an area for reinvention.

As noted above, OWCP has requested FY 2000 funds for intensive training of its claims staff. In that context we hope to develop a comprehensive "Communications Redesign" to help both claims and support staff meet their responsibilities, both on the phone and (for claims staff) in writing. Depending upon the availability of resources, such an initiative could involve some or all of the following steps:

- Identify the specific demands placed on contact reps and claims staff, and train accordingly. People call and write for a variety of reasons. The program hasn't had a standardized protocol for dealing with different kinds of issues, either by phone or in writing, nor have we had a uniform process for handling troubled or irate callers. While every office has evolved processes for elevating complaints about service, these channels are not formalized and are not always adequately understood by staff or made clear to customers.

- Identify the skills needed to handle inquiries. These include interpreting questions, knowing the answers, explaining matters clearly, staying calm in the face of adversity, identifying and avoiding extraneous issues, and avoiding legal and medical jargon. In written responses, it is important to know when to quit, and on the phone, it is important to know when to refer a problem call to someone else.

- Train both support and examining staff. Basic training in communication and conflict management would be combined with inculcation of the protocols and complaint referral procedures discussed above. We hope to include this as a component of the training to be funded in FY 2000.

- Devise a way to monitor performance and measure results, again in conformance with GPRA principles. We would need to make sure that responses made are made well and politely, and identify where responses are left unmade. Also, we would need to ensure that responses are timely, and monitor such issues as voice mail boxes filling up.

- Finally, this initiative would also involve a reexamination of the program's systems for generating form letters -- in conjunction with the ADP redesign project which will provide much fuller support for claims examiners in terms of automatically generated correspondence triggered by specific events or milestones.

I again want to thank the Subcommittee for inviting OWCP to address these matters today.

Mr. HORN. If I might point out, just to get it in the record, because it is sort of relevant and I was going to ask it anyhow. You mentioned the 10 percent increase. We are now in fiscal year 1999, and we are considering fiscal year 2000. Has your office, program within Labor, and you personally asked for the appropriate resources in the last 2 years or did you ask even earlier, like 1993–1994? After our hearing in Long Beach, I would hope that somebody got the message and said, gee, let's solve some of these problems. Have you asked for those resources at your program level?

Mr. HALLMARK. I believe the record will show that OWCP has been seeking substantial additional staff resources at least, probably before this but certainly starting with the 1992 budget. A small number of staff were approved—additional staff were approved in 1992. We renewed those requests. A small additional increment was added in 1995. Unfortunately, in 1996, our resources were cut; and we were obliged to conduct a reduction in force.

Mr. HORN. Let me ask—

Mr. HALLMARK. So there is a long history of trying to accomplish that.

Mr. HORN. So your program reports to the Assistant Secretary for Employment Standards, essentially?

Mr. HALLMARK. Correct.

Mr. HORN. He or she, in turn, reports to a Deputy Secretary of Labor and the Secretary of Labor. Did they approve your recommendations for more funding to help get at the backlog that Mr. Riordan mentioned? Where did it go up the line? How far did it go positively, let's say, from your standpoint? Did you have the support of the Assistant Secretary and the Deputy Secretary and the Secretary?

Mr. HALLMARK. I'm casting my memory back over the number of years that we are talking about here which, unfortunately, now is 7 or 8. My recollection is that, in most of those years, the requests made by OWCP were, in fact, at least in part passed forward through the system. I can't say with certainty that they appeared as part of the President's budget in every case, but in most cases, yes, they did, at least in part.

Mr. HORN. So the Office of Management and Budget, then, made a decision one way or the other. And then comes the question, did the Secretary appeal the decision to the President, if it was a cut; and what eventually happened?

I don't expect you to carry all those figures in your head right now. What I want to do is make a little matrix of that and put it in the record at this point, without objection. Then I would like to know if the President did make a recommendation and agreed with your recommendations. What did the Congress do in 1993, 1994, which was a Democratic Congress, and after that in Republican Congresses? Did they cut you? Did they add to it? Was there a difference between the Senate and the House?

If you could just get your fiscal people to give us that type of chart. And staff here will work with you. They will know what I'm after here. It is sort of my usual management routine of, did you get it or didn't you and who sat on it so we can pin a little responsibility.

If it is Congress' problem, fine, we will deal with them, the Authorization Committee and Appropriations Subcommittee. If it is the administration's problem, fine, we will deal with them. But I would just like to have that—to the degree to which people asked for the resources they need and justified it.

[The information referred to follows:]

Budget History (\$000)		EMPLOYMENT STANDARDS ADMINISTRATION									
File: 2000CONBRF/History2		7/21/99									
Page 13											
Program		FY 1998				FY 1999				FY 2000	
		CONG. Request	House Mark	Senate Mark	Appropri- ation	CONG. Request	House Mark	Senate Mark	Appropri- ation	Comp. Request	Request
OWCP: (FECA) (LSWH)		81,199	77,783	77,783	77,783	76,759	76,759	76,759	76,759	80,369	
		72,652	69,246	69,246	69,246	67,865	67,865	67,865	67,865	71,030	
		8,537	8,537	8,537	8,537	8,894	8,894	8,894	8,894	9,339	
OWCP: (Black Lung) (LSTF)		27,611	26,844	26,844	26,844	31,805	31,805	31,805	31,805	30,094	
		25,851	25,851	25,851	25,851	29,881	29,881	29,881	29,881	28,354	
		1,760	983	983	983	1,924	1,924	1,924	1,924	1,740	

EMPLOYMENT STANDARDS ADMINISTRATION														
Program	FY 1996						FY 1997							
	Agency CONG. Request	HOUSE Mark	SENATE Mark	Appropri- ation	Revisions		Transfer to ILAB	Revised FY 1996	Agency CONG. Request	HOUSE Mark	SENATE Mark	Appropri- ation	Revisions	
					Admin. & Salaries Supplies	Excesses							Salaries & Public Expenses	(Pl. 104-208) Salaries & Public Expenses
Budget History (\$000)														
File: 200CONBR\History2														
Page 12														
OWCP:	82,937	70,693	72,604	73,736	(126)	(151)	(300)	73,159	80,222	71,896	75,710	(40)	0	75,670
(FECA)	74,475	62,878	64,577	65,641	(112)	(134)	(300)	65,095	71,879	63,764	67,367	(40)	0	67,327
(LSHW)	8,462	7,815	8,027	8,095	(14)	(17)	0	8,064	8,343	7,932	8,343	0	0	8,343
OWCP:	30,008	26,737	29,317	28,057	(73)	(87)	0	27,857	28,841	26,767	26,767	(18)	0	26,749
(Black Lung)	28,339	25,759	28,339	27,050	(71)	(85)	0	26,894	25,784	25,784	25,784	(18)	0	25,766
(LSIF)	1,669	978	978	1,007	(2)	(2)	0	1,003	1,057	983	983	0	0	983

Budget History (Dollars in thousands)										
File: 2000CONBRFHistory2										
Page 11										
FY 1995										
Program	FY 1995 Agency Request	Rent & Procurement Reductions	Revised Agency Request	FY 1995 House Allotment	FY 1995 Senate Allotment	P.L.103-333 Limitation on Spending	FY 1995 Enacted	FY 1995 Rescission P.L. 104-19	Revised FY 1995 Enacted	
OWCP: (FICA) (LSHW)	81,694	(827)	81,057	75,024	76,639	(214)	76,425	(22)	76,403	
	73,092	(930)	72,549	67,141	68,165	(188)	67,376	0	67,376	
	8,585	(177)	8,316	7,883	8,474	(25)	8,449	(22)	8,427	
OWCP: (Black Lung)	29,566	(465)	29,101	28,985	28,565	(60)	28,905	0	28,566	
	28,359	(453)	27,906	27,906	27,903	(58)	27,848	(338)	27,509	
(LSTF)	1,207	(12)	1,195	1,059	1,059	(2)	1,057	0	1,057	

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07/21/99

Budget History (Dollars in thousands)
File: 200CONBRF/History2

Program	FY 1993				FY 1994				FY 1994				FY 1994			
	FY 1993 Agency Request	FY 1993 House Allowance	FY 1993 Senate Allowance	FY 1993 Initial Approp.	P.L. 103-364 Reduction	FY 1993 Enacted	Revised FY 1993 Enacted	FY 1994 Agency Request	FY 1994 House Allowance	FY 1994 Senate Allowance	FY 1994 Enacted	P.L. 103-311 Rescission	FY 1994 Agency Request	FY 1994 House Allowance	FY 1994 Senate Allowance	FY 1994 Enacted
OWCF:	73,367	70,298	71,399	70,903	(657)	70,336	70,336	71,923	71,923	71,923	71,923	0	71,923	71,923	71,923	71,923
(FECA)	64,554	61,581	62,933	62,414	(499)	61,915	61,915	63,506	63,506	63,506	63,506	0	63,506	63,506	63,506	63,506
(LSHW)	8,763	8,417	8,466	8,489	(88)	8,421	8,421	8,417	8,417	8,417	8,417	0	8,417	8,417	8,417	8,417
OWCF:	39,476	39,418	39,403	39,418	(8)	39,410	39,410	39,613	39,613	39,613	39,613	(248)	39,613	39,613	39,613	39,613
(Black Lung)	28,419	29,413	29,419	29,419	0	29,419	29,419	29,613	29,613	29,613	29,613	(248)	29,613	29,613	29,613	29,613
(LSTF)	1,056	999	987	999	(8)	991	991	999	999	999	999	0	999	999	999	999

Budget History (Dollars in thousands)														07/21/99					
Fisc. 2000CONRR/Histoy 2																			
Program	FY 1992 Agency Request	DOL Transfer	Revised FY 1992 Request	FY 1992				Initial Approp.	Sec. 513(a) PL 102- 170 Reduction	Reprogram FY 1992		FY 1992 Ex.Dir.	FY 1992 Exacted						
				House Allowance	Senate Action		Ex. Dir.			Reduction	Ex. Dir.								
					Reduction	Reduction													
OWCP:	67,985		67,985	67,985				67,985	(1,361)	(157)		65,467							
(FECA)	59,513		59,513	59,513				59,513	(1,176)	(134)		58,203							
(LSHW)	8,472		8,472	8,472				8,472	(185)	(23)		8,264							
OWCP:	30,807		30,807	30,807				30,807	(26)	0		30,781							
(Black Lung)	29,772		29,772	29,772				29,772	0	0		29,772							
(LSTF)	1,035		1,035	1,035				1,035	(26)	0		1,009							



**REVIEW OF MEDICAL
REIMBURSEMENTS AND
AUTHORIZATION
OF SURGICAL REQUESTS
FOR THE OFFICE OF WORKERS'
COMPENSATION PROGRAMS**

**U.S. Department of Labor
Office of Inspector General
Office of Analysis, Complaints and Evaluations**

Report Number: 2E-04-431-0001
Date: May 17, 1999

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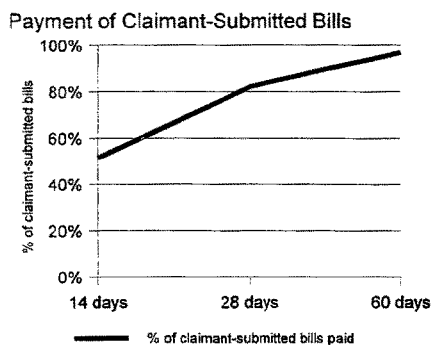
Acronyms

CPT	Current Procedural Terminology
FECA	Federal Employees Compensation Act
GAO	General Accounting Office
OIG	Office of Inspector General
OWCP	Office of Workers' Compensation Programs

EXECUTIVE SUMMARY

The Office of the Inspector General (OIG) conducted this review in response to testimony presented at a July 6, 1998, Congressional hearing of the House Government Reform and Oversight Committee, Government Information and Technology Subcommittee that was critical of the Office of Workers' Compensation Programs' (OWCP) administration of the Federal Employees' Compensation Act (FECA). After analyzing the hearing transcript, OWCP's written response to allegations made by the 19 claimants during that hearing, and relevant OIG and General Accounting Office (GAO) reports, we decided to examine two issues that remained unaddressed -- timeliness of claimant reimbursement for out-of-pocket medical expenses and requests for surgical authorizations.

We found that reimbursement of claimants' out-of-pocket expenses is not a substantial issue. OWCP data show that reimbursement of claimants represents only 3 percent of all medical bills paid by OWCP. OWCP surpasses the 95 percent 60-day performance standard by paying 96.9 percent of all claimant-submitted bills in 60 days, although it falls somewhat short of the 90 percent standard in 28 days by paying 82.1 percent of claimant-submitted bills within 28 days. However, OWCP told us that in January 1999, they implemented an automated bill review system. They expect this new system to increase the percentage of claimant-submitted bills paid in 28 days.



Pharmacy bills are the largest category of claimant reimbursements. OWCP has implemented an electronic billing system that allows pharmacies to bill OWCP directly, eliminating the need for claimant out-of-pocket expenses. OWCP records show that after only four months, the new system has reduced claimant-submitted pharmacy bills by 10 percentage points.

OWCP deals with two different types of surgeries—emergency and non-emergency. If an employee suffers a traumatic injury at work and requires emergency surgery, the employing agency is responsible for authorizing the medical treatment within four hours of injury. Our review examined OWCP's handling of requests for non-emergency surgery.

OWCP has not set a performance standard in this area. Although we contacted many different sources such as the Workers' Compensation Research Institute and State Workers' Compensation Programs, we did not find a standard with which to measure OWCP's performance. We did not find a pattern of delays in the case files we examined. In addition, OIG complaint letters contain few complaints regarding delays in reimbursement and surgical authorizations.

We recommend that OWCP set a performance standard for responding to surgical requests to reduce claimant uncertainty about the process. OWCP's response might be in the form of a request for additional information, an appointment to see a physician for a second opinion exam or an approval for surgery. Four of OWCP's twelve district offices already track surgical requests and have set performance standards. The performance standards range from 7 to 10 days.

The following report contains our analysis, findings and recommendation regarding OWCP's response to claimants' requests for reimbursement for out-of-pocket medical expenses and surgical authorizations. We provided a draft of this report to OWCP. The agency's response is found in the body of the report and in its entirety in Appendix D. OWCP did not agree to set a performance standard at this time. We will consider our recommendation resolved once OWCP sets a performance standard for responding to surgical requests.

I. Purpose

This review assesses the timeliness of OWCP's response to claimants' requests for out-of-pocket expenses and surgical authorizations. On July 6, 1998, Congressman Stephen Horn of the House Government Reform and Oversight Committee, Government Management Information and Technology Subcommittee held a hearing in Long Beach, California on OWCP's service to injured employees under the FECA. The purpose of Congressman Horn's hearing was to find ways to improve the federal employees' compensation system. Nineteen claimants testified, either on a panel or from the audience. The claimants expressed a wide variety of complaints that pointed to possible anti-claimant bias on the part of OWCP, including difficulties with adjudication of claims, problems communicating with district offices, disputes with employing agencies and delays in reimbursement of claimant out-of-pocket medical expenses and surgical authorizations.

In a July 31, 1998 letter to Chairman Horn, OWCP addressed the agency's handling of each of the 19 cases. According to OWCP, only two involved delays with surgical authorizations and none related to delays in reimbursing claimant out-of-pocket medical expenses. Of the remaining 17 cases, seven involved delays on the part of OWCP unrelated to reimbursement of claimants and surgical authorizations. The other 10 involved lack of medical evidence, claimant confusion over the process and other issues which were the responsibility of the employing agencies.

Earlier OIG and GAO reports found no evidence of anti-claimant bias in OWCP's selection and payment of second-opinion physicians or handling of claims. In 1998, the OIG study, *Review of FECA Program Administration*, examined the OWCP's acceptance of initial claims for benefits, the termination of benefits and the appeals process administered by the Branch of Hearings and Review. OIG did not find a systemic anti-claimant bias but, to the contrary, found OWCP commitment to improving the quality of service to claimants and ensuring cost-effective administration of the program.

In 1994 the GAO report, *Federal Employees' Compensation Act - Non Evidence That Labor's Physician Selection Processes Biased Claimants' Decisions*, investigated allegations that OWCP (1) "shopped" for physicians to conduct second-opinion exams and independent medical examinations who would be predisposed against claimants and (2) took longer to reimburse claimants' physicians than to reimburse physicians selected by OWCP. GAO found no evidence to support either allegation. OWCP's process for selecting physicians

provided a reasonable level of certainty that the physicians were selected in an unbiased manner. While GAO did not distinguish between payments made directly to providers and reimbursements to claimants, GAO found that OWCP was meeting its overall bill payment performance standards.

After analyzing the hearing transcript, OWCP's written response to allegations made by the 19 claimants during that hearing, and the OIG and GAO reports, we identified two issues that remained unaddressed—timeliness of claimant reimbursement for out-of-pocket medical expenses and requests for surgical authorizations.

Accordingly, the objective of this review was to determine whether OWCP was responding in a timely manner to claimants' requests for:

- Reimbursement for out-of-pocket expenses and
- Surgical authorizations.

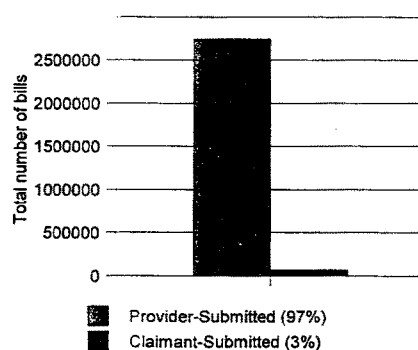
Our review was conducted in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

II. Findings

1. Reimbursement of Claimant Out-of-Pocket Medical Expenses

As Figure 1 shows, claimant-submitted bills are only 3 percent of the 2,817,021 bills OWCP paid in fiscal year 1998.

Figure 1: Provider-Submitted vs Claimant-Submitted Bills



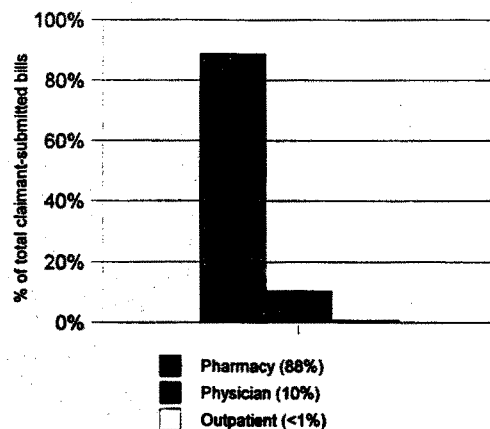
We found that OWCP surpasses the 95 percent 60-day performance standard by paying 96.9 percent of all claimant-submitted bills in 60 days, but falls somewhat short of the 90 percent standard for 28 days by paying 82.1 percent of claimant-submitted bills within 28 days.¹ However, OWCP told us that in January 1999,

¹At the time of this report, the agency was unable to retrieve dollar amounts to correspond with these percentages.

they implemented an automated bill review system. Prior to this new system, OWCP had to manually review each bill. OWCP expects this new system to shorten the time for processing bills and therefore increase the percentage of claimant-submitted bills paid in 28 days. Furthermore, an electronic billing system OWCP has put in place is expected to reduce the overall percentage of claimant-submitted bills.

As Figure 2 illustrates, pharmacy bills are 88 percent of all claimant-submitted bills, physician bills are 10 percent and outpatient bills are less than 1 percent.

Figure 2: Categories of Claimant-Submitted Bills



We found that for July 1, 1997, through July 14, 1998, OWCP exceeded the 60 day standard by paying 97 percent claimant-submitted pharmacy bills in 60 days and came very close to the 28 day standard by paying 83 percent in 28 days. In fiscal year 1998, OWCP did not meet performance standards in either claimant-submitted physician bills or claimant-submitted outpatient bills. Although

pharmacy bills are by far the largest category of claimant-submitted bills that OWCP reimburses, they represent only 2 percent of all medical services paid for by OWCP. The remaining two categories -- claimant-submitted physician bills and claimant-submitted outpatient bills -- are only .2 percent and .02 percent respectively of all medical services paid for by OWCP.

In an effort to reduce claimant-submitted bills, OWCP implemented an electronic billing system for pharmacy bills -- the bulk of all claimant-submitted bills -- in July, 1998. The system allows participating pharmacies to bill OWCP directly, thus eliminating the need for claimants to pay pharmacy bills out-of-pocket and request reimbursement from OWCP.

The year before the electronic billing system was implemented, claimant-submitted bills were 22 percent of the total pharmacy bills. Four months after the electronic billing system was in place, the percentage dropped to 12 percent. OWCP provides lists of participating pharmacies to district offices and posts them on the internet. OWCP's efforts to reduce claimant-submitted bills appear to be on the right track and are showing early success.

Also, in August 1997, OWCP introduced a *Claimant Medical Reimbursement Form*. This form tells claimants what documentation OWCP requires to reimburse out-of-pocket medical expenses. By completing the form, a claimant greatly reduces the possibility of OWCP returning their bill to request additional information, thus reducing delays in claimant reimbursement.

OWCP is working on several other technological innovations to further streamline the bill payment process. OWCP plans to have the new computer system in place by July 2001. Where feasible, the new system will use imaging and electronic capture of data, instead of manual data entry. This will allow OWCP to establish more electronic billing programs like the one currently in place for pharmacies.

OWCP is also in the process of imaging all its case files and medical bill batches. Bill batch imaging gives claims examiners quicker access to specific bills. Instead of searching for the paper copy, the staff will be able to quickly access an electronic copy. OWCP expects this innovation to improve the timeliness of their responses to claimants' needs.

2. OWCP's Timeliness in Processing Surgical Authorizations

OWCP has not set a performance standard in this area. We contacted a wide range of sources such as the Workers' Compensation Research Institute and State Workers' Compensation Offices; however, we found no standard against which to benchmark OWCP's performance.

Some OWCP district offices attempt to track the time between request and authorization manually. For example, the New York district office has dedicated a fax line to receiving medical authorization requests. Their goal is to respond in one week whenever possible. In Cleveland, each claims examiner maintains a log of incoming correspondence that includes surgical authorization requests. The claims examiners try to respond to the request within 10 working days of its receipt. Tracking systems are left to the discretion of the district offices because OWCP's current computer system is not capable of tracking this information. However, OWCP's national management told us that they have directed each district office to develop a way to track telephone medical authorization requests, which includes requests for surgical authorizations. OWCP states that all district offices are currently conducting tracking of telephone requests for medical authorizations and are reporting on a quarterly basis to the national OWCP office.

In order to get an idea of OWCP's timeliness in processing surgical authorizations, we measured the elapsed time between OWCP's receipt of a request for surgical authorization and OWCP's approval in 69 Philadelphia case files.² We also noted the number of Congressional inquiries in an effort to determine whether there were patterns of delays in responding to these inquiries. In addition we reviewed OWCP claimant complaint letters received by the OIG.

Elapsed Time

Our random sample of 69 cases drawn from the Philadelphia case files included three high frequency surgical procedures: (1) arthroscopic knee surgery, (2) rotator cuff repair and (3) herniated disk repair. We measured the elapsed time between the surgical authorization request and OWCP's authorization.

Although the overall range for processing surgical authorization requests was 0 to 354 days, ninety-three percent of the cases fell within the range of 0 to 85

²OWCP does not keep a record of the number of surgical authorizations denied.

days. Leaving the five atypical cases (354, 326, 225, 124, and 102 days) out of our calculations, we found that on average, OWCP processed surgical requests in 26 days, with the median (mid-point) being 17 days and the mode (most frequent value), which occurred 5 times, 7 days. The range shows what program officials told us -- that the time it takes OWCP to process a surgical request varies greatly depending on the case.

Congressional Inquiries

Our sample from the 69 Philadelphia case files included three files containing Congressional correspondence. Each case was unique and did not appear to be part of a pattern of delays on the part of OWCP.

1. On May 6, 1998, the Philadelphia District Office received a fax from Congressman Joseph M. McDade's office inquiring about the status of a claim. Congressman McDade was particularly concerned about delays in authorizing surgery and reimbursing pharmacy bills. The District Office responded to the fax with a May 20th letter from the District Director. The Director stated that the office had received the claims for reimbursement and the claimant should expect payment in approximately two weeks. The office never received a request for authorization of surgery.

Based on the case file, it appears that the claimant's doctor sent the letter requesting surgery to the claimant's employer, the U.S. Postal Service, on April 23. The Postal Service received the letter on April 29, but failed to forward it to the OWCP District office. After the District Office received the surgery request on June 9, it authorized the surgery on June 15.

2. On May 11, 1998, the Philadelphia District Office received a letter from Congressman Bud Shuster inquiring about the status of a claim. OWCP replied in a May 21 letter stating that the claim had been approved and the claimant had been informed of this by letter. OWCP received the claimant's request for authorization on March 27, 1998. A letter to the claimant appears in the file. The letter is not dated, but its placement in the file suggests that it was sent prior to the May 11th Congressional inquiry.

3. On April 8, 1997, the Philadelphia District Office received a letter from Congressman Bud Shuster requesting information about a claim. The claimant injured his knee on July 9, 1996. The claimant waited for approval, but OWCP did not receive his claim until January 16, 1997.

The District Office responded to Congressman Shuster in a letter dated April 18, 1997. The letter explained that on January 30, 1997, OWCP sent the claimant a letter informing him that the information accompanying his claim was not sufficient for OWCP to determine eligibility for FECA benefits. The claimant sent additional information on February 26, 1997. OWCP approved the claim and surgery on April 11, 1997, and sent a letter informing the claimant.

OIG Data

Currently, claimant complaints regarding delays in reimbursement and surgical authorizations are infrequent. Our analysis of fiscal year 1998 OIG complaint letters shows 64 letters concerning OWCP. Of the 64 letters, 7 involved complaints about reimbursements and/or surgical authorizations. The 7 letters contained 4 complaints about medical reimbursements and 5 about delays in processing surgical authorizations.

III. Conclusions

We found that the timeliness of OWCP's reimbursement to claimants for out-of-pocket medical expenses is not a substantial issue. OWCP data show that claimant-submitted bills are only 3 percent of the total number of medical services paid for by OWCP. Overall, bills are paid in a timely manner and, furthermore, OWCP has implemented an electronic billing system for pharmacy bills, which in only four months has reduced the number of claimant-submitted bills by 10 percentage points.

OWCP has not set a performance standard for responding to requests for surgical authorizations. Although our review of 69 Philadelphia case files did not reveal a pattern of delay and claimant letters received by the OIG indicate that claimant complaints regarding delays in surgical authorizations are infrequent, we recommend that OWCP set a performance standard for responding to requests for surgical authorizations.

IV. Recommendation

We recommend that OWCP set a performance standard for responding to surgical requests. OWCP's response might be in the form of a request for additional information, an appointment to see a physician for a second opinion exam or an approval for surgery. Four of OWCP's twelve district offices already track surgical requests and have set performance standards. The performance standards range from 7 to 10 days.

During the hearings claimants expressed confusion over OWCP's processing of claims and surgical requests. Setting a performance standard for responding to surgical authorizations would not only enable OWCP to determine district offices' timeliness in this area, but may also eliminate a great deal of claimant uncertainty.

OWCP Response

"OWCP plans to review its practices in responding to surgery requests given the recommendation of your study and your emphasis on identifying more precisely where and how to focus our efforts at improving customer service. However, there are several reasons that we cannot establish a performance standard at this time."

OIG Conclusion

On the basis of this response, we do not consider this recommendation resolved.

Major Contributors to this Report:

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 Teserach Ketema, Team Leader
 Mary Elizabeth McNeill, Project Leader
 George T. Fitzelle, Program Analyst

Appendix A**Background**

The FECA [5 USC 8103(a)] requires that any civilian employee of the United States who is injured while in the performance of duty, be provided with the medical services and supplies needed to treat the injury. The rules governing reimbursements, surgical authorizations, and timeliness follow.

Reimbursements

OWCP recognizes two types of reimbursements: provider-submitted and claimant-submitted. Medical providers can directly bill OWCP for their services (provider-submitted) or a claimant can pay for medical services out of his own pocket and request reimbursement from OWCP (claimant-submitted). This study focuses on claimant-submitted reimbursements. Claimant-submitted bills fall into three categories: outpatient, physician and pharmacy.

To be reimbursed, a claimant must submit (1) a copy of an itemized standard billing form (HCFA-1500, UB-92 or for pharmacies, the Universal Billing Form) which provides the tax identification number of the vendor as well as each line item paid and (2) a copy of a canceled check or proof of payment.

Surgical Authorizations

The FECA procedures manual states that in order to ensure payment, a claimant must obtain prior authorization for surgery whenever possible. A physician must request the surgery and provide medical evidence to show its necessity. However, if an employee suffers a traumatic injury at work and requires emergency surgery, the employing agency is responsible for authorizing the medical treatment within four hours of injury by issuing a CA-16 form. The CA-16 guarantees the payment of medical treatment up to 60 days after the injury unless OWCP withdraws authorization in writing.

The time OWCP takes to authorize non-emergency cases varies depending on the complexity of the condition. For example, before OWCP will authorize back surgery, the claimant must obtain a second opinion or a consultant's review of the medical evidence. The FECA procedures manual states that an in-house review by a consultant should occur within 21 days of receipt of the request for surgery, and any second opinion examination required should be accomplished within 40 days. On

the other hand, OWCP does not require second opinion exams or a consultant's review for injuries such as carpal tunnel surgery. A claims examiner may be able to authorize the surgery based on the information already contained in the case file.

According to OWCP officials, many of the factors contributing to the length of processing time are beyond OWCP's control. For example, OWCP may need additional medical information from the physician or a claimant may postpone an appointment for a second opinion. The claims examiner may request additional information regarding how the injury occurred to ascertain that the surgery is necessary and concerns a work-related injury.

Timeliness

The OWCP Operational Plan includes a Timeliness Performance Measure for processing (paying or denying) medical bills -- 90 percent are to be processed in 28 days and 95 percent in 60 days. However, OWCP does not have a timeliness standard for processing requests for surgical authorizations. OWCP officials told us that it is difficult to set a performance standard for processing surgical authorizations because the time it takes to authorize a procedure varies depending on the type of case. We contacted multiple sources such as the Workers' Compensation Research Institute and State Workers' Compensation Programs, but did not find a standard with which to measure OWCP's performance.

Appendix B

Methodology

To gather background information, we examined two pertinent previous studies--OIG's 1998 study, *Review of FECA Program Administration* and the 1994 GAO report, *Federal Employees' Compensation Act - Non Evidence That Labor's Physician Selection Processes Biased Claimants' Decisions*. We then began our current review. We started with the examination of OWCP's performance in reimbursing claimants. Subsequently, we reviewed agency performance in processing surgical authorization requests. Table 1 of Appendix C lists the data sources we reviewed.

To determine OWCP's performance in reimbursing claimants for out-of-pocket medical expenses, we conducted interviews with OWCP senior management and obtained OWCP bill payment data. We did not verify the statistical data obtained from OWCP's bill payment system. According to an OWCP official, OWCP defines a bill as a service or prescription and most claimant reimbursement requests involve a single bill. Outpatient and physician bill data include outpatient and physician bills paid from October 1, 1997 to September 30, 1998. Pharmacy bill data include pharmacy bills paid from July 1, 1997 to July 14, 1998. The three month difference in reporting periods is so small as to not be material to our review. The two sets of data give an informative picture of OWCP's bill payment performance. In addition we analyzed complaint letters regarding delays in reimbursement and authorization for surgery sent to the OIG in fiscal year 1998 (October 1, 1997 through September 30, 1998).

To study OWCP's performance in processing surgical authorizations, OWCP furnished summaries of administrative practices in district offices. To gain further insight into the details of processing surgical authorizations, we visited the Philadelphia district office and examined a random sample of case files. We selected the Philadelphia District Office because OWCP data showed its performance was in the average range among OWCP district offices.

To develop the random sample, we first reviewed a list of surgical procedures commonly billed under FECA. OWCP created a list of frequently billed Physician Current Procedural Terminology (CPT) codes by extrapolating from bills paid for the last quarter of fiscal year 1998. Using the CPT codes billed, we were able to identify

the procedures represented by the codes and determined the most frequently billed procedures.

Two of the most frequent codes were carpal tunnel surgery and epidurals. However, we decided not to look at carpal tunnel and epidurals because neither procedure always requires a specific authorization. We chose shoulder, knee and back surgery as these procedures always require authorizations, are common and less likely to be an emergency procedure necessitating an emergency authorization. Specifically, we looked at rotator cuff repair (CPT # 23420), knee arthroscopy (CPT # 29881) and herniated disk repair (CPT # 63030). We included herniated disk repair because it represented a case that required a second-opinion exam before authorization. This requirement indicates that OWCP would take longer to authorize this procedure. We determined that these codes would provide an adequate sample to measure the number of days it takes OWCP to authorize a requested surgery.

After determining which codes we would review, we used a stratified random sampling for attributes method to select cases allocated proportionally among the three codes. This sampling method yielded 74 cases for review.

During our visit to Philadelphia we reviewed 69 case files and gathered information on selected variables including those related to identified time-frames. Five of the 74 cases we selected were not at the Philadelphia office at the time of our review. More specifically, the variables we recorded included the type of procedure and number of days between the date of request and the date of authorization.

Appendix C

Table 1
Data Sources Reviewed

Transcript of Proceedings held before Chairman Horne, July 6, 1998 in California. Reported by Bill Warren for York Stenographic Services, York, PA.

July 31, 1998 OWCP's Response to Claimant Testimony

OWCP Bill Payment Data

Pharmacy bills (7/1/97 - 12/15/98)

Physician bills (Fiscal Year 1998)

Outpatient bills (Fiscal Year 1998)

OIG Complaint Letters (Fiscal Year 1998 - January Fiscal Year 1999)

Philadelphia District Office Case Records

271

Appendix D

Agency Response

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Washington, D.C. 20210



May 17, 1999

File Number:

MEMORANDUM FOR:

AMY FRIEDLANDER
OIG

FROM:

Shelby Hallmark
SHELBY HALLMARK
OWCP

SUBJECT:

OIG Report No. 2E-04-431-0001

You requested our review of the draft report dated May 14 and whether OWCP is prepared to implement your recommendation for a performance standard on surgical requests. OWCP plans to review its practices in responding to surgery requests given the recommendation of your study and our emphasis on identifying more precisely where and how to focus our efforts at improving customer service. However, there are several reasons that we cannot establish a performance standard at this time.

OWCP has set numerous performance standards over the years, and has an excellent track record of managing performance to ensure that these exacting standards are met. Following the tenets of the GPRA, we believe that goals and measures should be established for those aspects of our work which are critical to our mission and which relate to areas needing real improvement.

We agree that it is essential that surgical requests be handled timely. In fact, your report indicates that it did not find a pattern of delay in the handling of these requests. Performance standards are currently in place for responses to telephone and written inquiries. Sampling in these areas, as well as automated telephone tracking systems, reveal that we are meeting these standards. To determine whether or in what areas there may be problems which warrant a new standard, in early 1999, the office began tracking telephone requests for medical authorizations and percentage of responses within three days. Once this information has been collected for a period of time, we will analyze the data and consider the need for an additional standard.

Secondly, your report notes the varied appropriate actions that can be taken on a surgical request. Depending on the specific surgery request, appropriate response can be immediate. Infrequently, it may take several months while additional examinations are being requested and performed. A standard set at a low number of days does not acknowledge those cases that appropriately require several additional actions before a decision. A standard set at a high number of days does not adequately serve those with surgeries that do not require additional review or information. A standard set at the median minimizes both situations.

Finally, it must be noted that tracking such information to the degree of precision required for a standard would be very difficult in our current ADP system. For this reason, the tracking of authorizations we recently mandated is being accomplished on a mainly manual basis. While we may determine that a standard should be set for some (or all) medical procedure requests, it may be very difficult to track performance against such a standard until our system redesign is completed in FY 2001. Simply setting a performance standard in this area may serve to allay claimant confusion, but OWCP has found that accurate and reliable measurement is essential to genuine performance improvement.



**REVIEW OF FEDERAL EMPLOYEES' COMPENSATION
PROGRAM CUSTOMER SERVICE SURVEYS
FOR THE EMPLOYMENT STANDARDS
ADMINISTRATION**

**U.S. Department of Labor
Office of Inspector General
Office of Analysis, Complaints and Evaluations**

Report Number: 2E-04-431-0002
Date: May 17, 1999

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Acronyms

FEC	Division of Federal Employees' Compensation
FECA	Federal Employees' Compensation Act
GAO	U.S. General Accounting Office
OIG	Office of Inspector General, U.S. Department of Labor
OMB	Office of Management and Budget
OWCP	Office of Workers' Compensation Programs

EXECUTIVE SUMMARY

The Office of the Inspector General (OIG) reviewed the Office of Workers' Compensation (OWCP) 1995 - 1998 customer service surveys, which were conducted by the Division of Federal Employees' Compensation (FEC). We analyzed the surveys' methodology in order to determine their accuracy and usefulness in providing sound information about customer service. Although OWCP has made efforts to improve the surveys each year, our analysis revealed the existence of methodological flaws in several areas, including survey design, measurement of customer service, sampling, response rate, and survey operations.

We make the following recommendations to enhance the accuracy of the data by improving the survey methodology and thus help OWCP judge and improve the quality of customer service provided by FEC.

Survey Design

1. Revise the questionnaire to shorten it, improve formatting of questions, and eliminate duplicate questions.
2. Reformat the questions to reduce the burden on claimants.
3. Conduct a pilot test for any future survey to increase clarity and relevance.

Measurement of Customer Service

Supplement reporting on customer service with focus group data.

Sampling

1. Draw a sample weighted to reflect the differences in sizes among the five claimant subgroups.
2. Analyze the sample to identify and eliminate overlap in sample selection from each subgroup.
3. Focus analysis of the survey data on only the key questions for which the research is being conducted.
4. Include additional analysis of samples, including: a comparison of the sample to the national claimant universe, using demographic variables and estimation of sampling error.

Response Rate

1. Establish higher standards for the response rate.
2. Include a cover letter on the contractor or DOL letterhead explaining at a minimum the importance of the survey, that participation is voluntary, a promise of confidentiality, and contact information for any questions.

3. Review follow-up procedures to ensure that nonrespondents who do not return the survey after the first postcard receive a new copy of the survey with a different cover letter stating the urgency of the project.

Survey Operations

1. Keep a record of the surveys returned in the mail as undeliverable and identify the reason why they were returned.
2. Ensure that the claimants sampled have the necessary experience with agency services to be able to answer the questions that are asked.
3. Keep a copy of the final data set as a permanent agency record.

The following report contains our analysis, findings, and recommendations regarding the methodology of the FEC customer service surveys. We provided a draft of this report to OWCP. The agency response is found in the body of the report and in its entirety in Appendix III. OWCP agreed to implement most of our recommendations if they conduct another survey and we consider those recommendations OWCP agreed with resolved. We are awaiting written confirmation of OWCP's corrective actions so that we can close the recommendations.

I. PURPOSE

The Office of the Inspector General (OIG) conducted a review of the Office of Workers' Compensation's (OWCP) 1994-1998 customer service surveys of claimants covered under the Federal Employees' Compensation Act (FECA). Because we believe that OWCP's ability to effectively measure customer satisfaction with FECA service is critical toward improving customer service, we analyzed the methodology of the surveys in order to determine whether they provide accurate and useful information.

Earlier OIG and U.S. General Accounting Office (GAO) reports found no evidence of anti-claimant bias on the part of OWCP¹. However, while conducting research that resulted in our *Review of Medical Reimbursements and Authorization of Surgical Requests for the Office of Workers' Compensation Programs* (1999), we requested a copy of the OWCP customer service survey report. Upon examination, we found methodological flaws in the questionnaire, casting doubt on the surveys' ability to provide accurate and useful information to the agency on customer service.

To assess the surveys' ability to provide useful information on customer service, we analyzed OWCP's customer service survey methodology in the following areas:

- Survey design,
- Measurement of customer service,
- Sampling,
- Response rate, and
- Survey operations

We conducted our review according to the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

¹ U.S. Department of Labor, Office of Inspector General, *Review of FECA Program Administration*, 1998. U.S. Department of Labor, Office of Inspector General, *Review of Medical Reimbursements and Authorization of Surgical Requests for the Office of Workers' Compensation Programs*, 1999. U.S. General Accounting Office, *Federal Employees' Compensation Act – Non Evidence That Labor's Physical Selection Processes Biased Claimants' Decisions*, 1994.

II. BACKGROUND, SCOPE, AND METHODOLOGY

1. Background

OWCP has conducted an annual customer service survey of claimants covered under FECA since 1995. The purpose of this survey, which focuses on customer service process issues and not on adjudication, is to measure agency performance to monitor customer service and for planning purposes. The agency samples five groups of claimants: periodic roll payment recipients (who were in receipt of payments released every 28 days for wage loss); daily roll payment recipients (claimants who receive intermittent payments for wage loss); employees injured but with no salary loss; employees whose claims for injury or disease have been denied; and employees who filed claims for occupational disease. Management uses this information for monitoring customer service and planning.

The first round of customer service surveys was conducted in-house. The agency sent the surveys to respondents in June, 1994 and reported on its findings in 1995. Since then, OWCP has hired a contractor to conduct the surveys. Customarily, OWCP mails the surveys in March and the contractor records and analyzes the data and submits a formal report on the findings by August of the same fiscal year. A contractor report has been submitted to the agency each year the survey has been conducted.

OWCP contracted out the second round of surveys to Market Research Bureau, Inc. of Washington, D.C. The contractor conducted the survey in September of 1995 and issued a report in January of 1996. The sampling for this survey appears to have used the previously determined claimant subgroups. According to the report, the agency mailed an equal number of questionnaires (600) to the five client categories for a total of 3,000. The returned questionnaires were sent to DOL and then forwarded to the contractor for analysis. Six hundred and thirty-five were returned for a response rate of 21%. The questionnaire included both open-ended and closed-ended questions and covered a range of customer service related issues. This survey also allowed respondents to provide verbatim comments that were not consistently analyzed from year to year.

Contractor D. M. Saunders was awarded the contract for the 1996 survey. To increase the response rate in this round, OWCP made some changes: it increased the sample size by 500 and mailed follow-up postcards to nonrespondents. Data collection was completed in February 1997 and the report was issued in May of 1997. OWCP reported the response rate for this survey to be 29%.

The original contractor, Market Research, Inc., was awarded the contract for the 1998 survey. The number of followup postcards was increased to two and respondents were

given a deadline for returning the survey. The report based on data collected for this survey was issued in 1998. In this survey the total response rate was 44%. To gather information on nonrespondents, a telephone interview supplemented this survey.

2. Scope

OIG reviewed customer service surveys conducted annually from 1994 -1998 by OWCP. Our analysis focused on survey methodology in the following areas: survey design, measurement of customer service, sampling, response rate, and survey operations. The following issues were outside the scope of our review: efforts that may be occurring at the district level to measure customer service; initiatives that OWCP may have taken to improve customer service in response to survey information; performance planning that may have been conducted using the data obtained from the surveys; and contracting issues with regard to procurement of the survey.

3. Methodology

To analyze the methodological issues within the scope of our review, we inspected customer service survey questionnaires and reports and written agency documentation, policies, and procedures on how the survey was conducted; and held interviews with OWCP officials.

III. FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

Based on all the information reviewed, OIG identified specific research methodology deficiencies that detract from the ability to make inferences about the claimant population from the sample. Our recommendations are designed to ensure that high quality data are available for the agency's management of customer service.

In order to make our recommendations immediately useful, we chose to only report on the most salient issues that need attention. The following sections list our findings, conclusions, and recommendations regarding (1) survey design, (2) measurement of customer service, (3) sampling, (4) response rate, and (5) survey operations.

1. Survey Design

Our review found problems and deficiencies with regard to the length, construction, and testing of the survey instrument. Specifically, we found that the questionnaire is too long; the number of answer formats, as well as the sequencing of questions, is problematic; and the questionnaire was never pilot tested. Appendix II contains copies of the questionnaires for the 1996, 1997, and 1998 reports.

Questionnaire length. The survey is four pages long, which is excessive for the goals of the annual customer service survey. The length of the questionnaire may encourage respondents to rush or skip items, reducing the quality of the response. By making the following revisions the questionnaire could be shortened to two pages. The first four paragraphs of the survey should be moved to a cover letter, any duplicate questions should be eliminated, and the questions could be reformatted to save space. Research shows that shorter, focused questionnaires have a higher probability of yielding reliable responses and higher response rates.

Questionnaire construction. The questionnaire construction is deficient. The questionnaire uses nine types of formats interspersed throughout. For example, question formats 1, 2a, 3, 4a, 4b, 5b, 5c, 6, and 7 in the 1998 survey are all different response formats (see Appendix II). Using many answer formats makes it difficult for the respondent to answer. The number of answer formats should be reduced to no more than four, and questions should be grouped by the answer format used. Screening questions should be located early in the questionnaire. For example, question 6 is a screening question and should be asked early in the questionnaire (see Appendix II). Placing screening questions early in the questionnaire has two advantages: it (1) prevents claimants from wasting their time when they do not have the experience necessary to answer and (2) strengthens survey findings. Improving the formatting will decrease the amount of time needed for completion and improve the probability of response. Claimants who lack the necessary experience will be screened out early and will not be burdened with completing the entire questionnaire.

Pilot test. No pilot test was conducted. The questionnaires were not tested with a small group of claimants before they were used with thousands of claimants over the last 3 years. Testing a questionnaire before it is mailed to the entire sample can help the agency learn whether the questionnaire is long and confusing to respondents and gauge whether it is asking relevant questions.

Recommendations

1. Revise the questionnaire to shorten it, improve formatting of questions, and eliminate duplicate questions.

OWCP Response

"We agree with #1 that the questionnaire could benefit from being revised to shorten its length, improve the formatting and eliminate duplicate questions."

OIG Conclusion

On the basis of OWCP's response, we consider this recommendation resolved. To close this recommendation, we would appreciate receiving a printed copy of the revised questionnaire that is sent out to respondents.

2. Reformat the questions to reduce the burden on claimants.

OWCP Response

"We agree with Recommendation #2 regarding the formatting of questions to put the like questions together. We would note, however, that OWCP/FEC has received no complaints from claimants through the past three years that there is undue 'burden' in completion of the questionnaires, as your report suggests."

OIG Conclusion

On the basis of OWCP's response, the issue of reformatting of questions is resolved. To close this recommendation, we would appreciate receiving a copy of the 1999 questionnaire as mailed to respondents. Although OWCP has received no adverse comments on the surveys, our assessment is that the low response rates may be claimant reaction to the "burden" created by a poorly-designed questionnaire. Research in this area shows that response rates go down when questionnaires are too long.

3. Conduct a pilot test for any future survey to increase clarity and relevance.

OWCP Response

"We agree with Recommendation #3 that a pilot test may be useful should we substantially revise the survey in the future."

OIG Conclusion

On the basis of OWCP's response, we consider this recommendation resolved. To close this recommendation, we would appreciate receiving a copy of the pilot test methodology and results.

2. Measurement of Customer Service

The use of a single questionnaire can result in unreliable reporting. It is advisable that the agency measure customer service through a variety of data sources instead of relying solely on one survey.

Reporting on customer service. Even if a survey is conducted perfectly, it cannot capture all the dimensions of a multifaceted topic such as customer service. Focus groups are particularly useful for exploring issues and can contribute a clear understanding of customer service². In addition, programmatic areas that require improvement are more likely to be identified, making it possible to correct customer service problems before they escalate.

Recommendation

Supplement reporting on customer service with focus group data.

OWCP Response

"We will review this suggestion, to supplement the use of a survey on customer satisfaction by using focus groups, depending on the availability of funding."

OIG Conclusion

On the basis of OWCP's response, we do not consider this recommendation resolved. As stated in our report, we believe that, to have valid and useful information, the agency needs to collect information from more than one source.

²William G. Zikmund, *Business Research Methods*, 3rd ed. (Belmont, CA: Wadsworth Publishing Company, 1989), p. 82.

3. Sampling

Examination of the sample revealed that it was not proportional to the different subgroups comprising the entire group of claimants. Further, our review disclosed that (1) the categories of claimant groups were not mutually exclusive, thereby raising the potential for overlap; (2) District Office comparisons were not statistically valid for the 1997 and 1998 surveys; and, (3) no analysis was conducted by the agency to ensure the sample approximated the entire group's characteristics.

The sample. The sample drawn was not proportional to the different subgroups comprising the entire group of claimants. The different subgroups of claimants vary in size. Some of the five groups are over-sampled while others are under-sampled. The five claimant subgroups, the number of claimants in each subgroup, and the number of questionnaires sent to each group can be found below in Table 1.

Table 1
Identification of 1998 FEC Claimant Subgroups and their Size

Claimant Subgroup at the time Sample Was Drawn	Number Of Claimants	Questionnaires Sent
1. Periodic Roll Payment Recipients (Claimants who were in receipt of payments released every 28 days for wage loss)	49,000	689
2. Daily Roll Payment Recipients (Claimants who received intermittent payments for wage loss)	9,200	680
3. Injured Employees with No Wage Loss	154,000	699
4. Employees Whose Claims for Injury/Disease Have Been Denied	24,000	618
5. Employees Who Filed Claims For Occupational Disease	27,000	700

For example, there are 154,000 claimants with no lost time from work and only 24,000 claimants who have been denied a claim. Sampling a virtually equal number from these two groups and the three others does not reflect the proportional differences in the national population. To report on the national

population of claimants, weighting of the sample needs to be considered.³ Because the sample drawn was not proportional to the different subgroups, it likely does not represent the national universe of claimants. This means that analytical results reported on the data gathered probably do not represent the national claimant population when responses of all subgroups are added to form an aggregate measure.

Categories of claimants. The categories of claimant groups are not mutually exclusive, thereby raising the potential for overlap. This means that a claimant may be included in more than one subgroup. The samples from 1994-1998 could have been contaminated by sampling the same claimant more than once. Analyzing the sample by running a cross reference of case file numbers to identify repeated cases will protect it against including respondents in more than one category. In addition, the analytical findings of the data can be accepted with greater confidence.

Comparison of District Office performance. Comparison of District Offices was not statistically valid for the 1997 or 1998 surveys, because (1) the sample sizes for comparison were not large enough and (2) comparing District Office performance was not one of the key research questions listed in the agency's documentation. Analysis of survey data should be focused on the key questions for which the research is being conducted to avoid findings that are not statistically valid. Otherwise, District Offices may receive invalid feedback on their performance. Research is enhanced by ensuring consistency and a focused analyses in each part of the survey.

Relationship between sample and claimant population. No analysis was conducted to ensure that the sample used approximated the characteristics of the entire group and to estimate the sampling error. We did not find that any comparison of the sample to the population was done using demographic variables such as age and gender. Conducting this analysis would indicate whether the samples drawn match the target FEC claimant population on such characteristics as age and gender.

Another analysis that is standard practice includes estimating sampling error. Sampling error is expressed by stating the confidence level and the confidence interval. In national opinion polling, the confidence interval is often expressed as +/- a given percentage (or probability that the sample represents the population of interest). Without such comparison, there is no assurance that the sample is representative of the population. Conducting analysis to determine the sample quality will ensure that the sample is representative of claimants nationwide.

³Earl Babbie, *The Practice of Social Research*, 5th ed. (New York: Wiley and Sons, 1989) p. 198

Recommendations

1. Draw a sample weighted to reflect the differences in sizes among the five claimant subgroups for reporting national aggregated data.

OWCP Response

"We agree with Recommendation #1, regarding weighting the sample. It should be noted, however, that OWCP's original design sought to determine satisfaction among each of the different types of claimants. We continue to need that level of specific information to guide our efforts."

OIG Conclusion

Based on OWCP's response, we consider this recommendation resolved. To close this recommendation, we would appreciate receiving written evidence that the sample was weighted to reflect the differences in sizes among the five claimant subgroups.

2. Analyze the sample to identify and eliminate overlap in sample selection from each subgroup.

OWCP Response

"We agree to analyze the sample to identify and eliminate any overlap in sample selection from each subgroup."

OIG Conclusion

Based on OWCP's response, we consider this recommendation resolved. To close this recommendation, we would appreciate receiving written evidence that OWCP has analyzed the sample to identify and eliminate overlap in sample selection from each subgroup.

3. Focus analysis of the survey data on only the key questions for which the research is being conducted.

OWCP Response

"We agree in general with #3 that focusing the analysis of the survey data on the key questions may improve the contractor's report. However, the program believes that discussion of district office level data, while not necessarily statistically valid, can be useful in guiding individual offices' communication plans."

OIG Conclusion

On the basis of OWCP's response, this recommendation is not resolved. We believe that feedback using data that may not be valid can be misleading rather than helpful. In this case, we do not know who the respondents are.

4. Conduct additional analysis of samples, including: a comparison of the sample to the national claimant universe, using demographic variables and estimation of sampling error.

OWCP Response

"We agree to conduct additional analysis of samples, including: a comparison of the sample to the national claimant universe, using demographic variables and estimation of sampling error."

OIG Conclusion

On the basis of OWCP's response, we consider this recommendation resolved. To close this recommendation, we would appreciate receiving written evidence that OWCP has conducted additional analysis of samples, including: a comparison of the sample to the national claimant universe, using demographic variables and estimation of sampling error.

4. Response Rate

The questionnaire response rate is considerably below the OMB standard of 80%. In addition, the agency needs to (1) reinstate the use of a cover letter to minimize claimant confusion and improve response rates, and (2) improve follow-up methods.

OMB standard. The response rate on the questionnaires is low. OMB has a response rate standard of 80% for all surveys, a standard that is supported by many research experts.⁴ The response rates on the surveys we analyzed were 21% in 1996, 29% in 1997, and 44% in 1998. Although the response rate is improving, it remains below standard. A low response rate means that the responses received may not be representative of the population of claimants, resulting in response bias. Setting a higher standard will improve the probability of a higher response rate, which will improve the accuracy of descriptions about the population.

Cover letter. After the first year, no cover letter was attached to the questionnaire that was sent to claimants. Using a cover letter has been found to improve the response rate.⁵ Sending the survey form by itself weakens communication on critical topics that impact the response rate. The cover letter included in the mailing with the questionnaire explains, at a minimum, the survey's importance and protections of anonymity or confidentiality, and offers a point of contact for additional information. The cover letter also provides a place for an explanation of technical terms such as "anonymous" or "confidential." The cover letter minimizes claimant confusion and highlights the importance of the survey. Claimants also understand their rights for participation or refusal.

Addressing nonresponse. Follow-up methods to address nonresponse have been inadequate. Specifically, follow-up methods were not substantially updated in response to inadequate response rates. Although OWCP has tried to increase the response rate through the use of postcards and telephone follow-up, the response rate remains low. One option for improving follow-up is to ensure that nonrespondents who do not return the survey after the first postcard receive a new copy of the survey with a different cover letter, stating the urgency of the project. By changing follow-up methods, the response rate can be improved, OWCP can learn what particular methods are most effective, and the data can be protected against response bias⁶.

⁴Zikmund, p. 175, and Babbie, p.242.

⁵Don A. Dillman, *Mail and Telephone Surveys: The Total Design Method* (New York: Wiley and Sons, 1978) p. 165, and Zikmund p. 176.

⁶A response bias occurs when nonrespondents self-select or respondents and tend to answer in a certain pattern, thus skewing the direction of responses.

Recommendations

1. Establish higher standards for the response rate.

OWCP Response

"We agree with Recommendation #1 that we seek to hold the contractor to a higher standard for response rates. We will include this in future work statements. However, we anticipate that the cost of requiring such a response rate may be substantially higher. Even using a fixed price contract with a mandated response rate, the OMB goal of 80% may not be attainable. OWCP also notes that it required the 1998 contractor to conduct a telephone survey which measured non-respondents' attitudes. This was not aimed at increasing response rates; this data set was used to determine whether or not the non-respondent population held views similar to those measured for the respondents. As reported in that survey, the two groups had comparable scores, providing increased confidence in the reported statistics."

OIG Conclusion

On the basis of OWCP's response, we do not consider this recommendation resolved. The agency's goal/expectation falls short of OMB's 80% response standard. We do not concur with OWCP's position regarding funding constraints. The recommendations we are making are standard professional practices and the contractor should conduct them for no additional charge. Implementing the recommendations can be expected to increase the response rate and allow savings through a decreased sample size. In addition, valid information will provide the organization with a valuable management tool that can help save resources by making the organization more productive.

2. Include a cover letter on the contractor or DOL letterhead explaining at a minimum the importance of the survey, that participation is voluntary, a promise of confidentiality, and contact information for any questions.

OWCP Response

"We agree with Recommendation #2, to add a cover letter from the FEC program to explain the importance of the survey."

OIG Conclusion

On the basis of OWCP's response, we consider this recommendation resolved. To close this recommendation, we would appreciate receiving a copy of the 1999 questionnaire with the cover letter.

3. Review follow-up procedures to ensure that nonrespondents who do not return the survey after the first postcard receive a new copy of the survey with a different cover letter stating the urgency of the project.

OWCP Response

"We do not agree with Recommendation #3 that an additional copy of the survey itself should be mailed, since the survey is anonymous and there is no record of who are the "non-respondents". To implement this would allow for duplicate submission of the survey by a given respondent (see Recommendation #2 regarding sampling, requiring that we avoid duplicate replies). OWCP has scrupulously maintained the anonymity of the survey respondents, and coding the surveys to allow identification of responses could undermine confidence in that process."

OIG Conclusion

On the basis of OWCP's response, we do not consider this recommendation resolved. OWCP may want to consider ensuring confidentiality, rather than anonymity (as is the practice in most customer surveys), to make it easier to implement this recommendation.

5. Survey Operations

We found problems/deficiencies with regard to the survey process, i.e., returned surveys, sample-questions relationship and record-keeping. Specifically, we found that no records are kept or analyses conducted of surveys returned in the mail as undeliverable; the sample drawn in 1998 did not support the questions asked in the questionnaire; and, no final data sets are kept on file by the agency after completion of analysis and reporting.

Returned surveys. No records are kept or analysis is conducted with surveys that are returned in the mail without ever having reached the addressee. Returned surveys were set aside without inquiry into why they were returned. As a result, follow-up postcards and questionnaires may have been sent to the original wrong addresses. Analyzing returned surveys enables the agency to correct potential mailing problems so that they do not reoccur each year.

Relationship between sample and questions. The sample drawn in 1998 did not support the questions asked in the questionnaire. The sample was pulled to include individuals who had some contact with the agency between October 1, 1996, and September 30, 1997. However, the questionnaire was not sent until the second week of March 1998. The questionnaire stated in eight places that respondents were to answer the questions based on their last 12 months of experiences with agency

services. However, many of the claimants included in the sample did not have experience with the agency within the last 12 months specified. As a result, many claimants may have believed the questionnaire did not apply to them. Since a high proportion of respondents did not have contact or experience with the office in the previous year, they had no basis to respond to questions relating to their satisfaction. When the sample supports the questions asked, the probability of a higher response rate increases and claimants who do not have the necessary experience with agency services are not unduly burdened. Establishing consistency between the sample and the questionnaire improves the quality of the data collected.

Record-keeping. No final data sets are kept on file after completion of analysis and reporting. No data sets are available for the surveys for any of the years that they were conducted, as a hard copy document or on a statistical or spreadsheet software program. Because of incomplete records, the data and research conducted can not be verified. In addition, an opportunity for subsequent research with the data sets is missed. Thus, valuable information is lost. Records that include data collected can be used to verify the research conducted. The data can also be analyzed to answer additional questions to support management decisions.

Recommendations

1. Keep a record of the returned surveys and identify the reason why they were returned.

OWCP Response

"We agree to keep a record of the returned surveys and identify the reason why they were returned."

OIG Conclusion

On the basis of OWCP's response, we consider this recommendation resolved. To close this recommendation, we would appreciate receiving written evidence that OWCP has kept a record of the returned surveys and has identified the reason why they were returned.

2. Ensure that the claimants sampled have the necessary experience with agency services to be able to answer the questions that are asked.

OWCP Response

"We agree that the time period we use as the basis for drawing the sample should be coordinated with the time frame specified in the questionnaire, and that the questionnaires should be distributed as close as possible to that time frame."

OIG Conclusion

On the basis of OWCP's response, we consider this recommendation resolved. To close this recommendation, we would appreciate receiving written evidence that claimants sampled in the next survey had experience with the office in the previous 12 months.

3. Keep a copy of the final data set as a permanent agency record.

OWCP Response

"We agree with Recommendation #3 that the full data sets derived from the questionnaire by the contract be provided back to FEC as one of the project deliverables."

OIG Conclusion

On the basis of OWCP's response, we consider this recommendation resolved. To close this recommendation, we would appreciate the opportunity to inspect the data sets received by OWCP.

Major Contributors

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Appendix I

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Appendix II

Agency Response

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Washington, D.C. 20210



May 17, 1999

File Number:

MEMORANDUM FOR:

AMY FRIEDLANDER
OIG

FROM:

Shelby Hallmark
SHELBY HALLMARK
OWCP

SUBJECT:

OIG Report No. 2E-04-431-0002

You requested our review of the draft report dated May 14 and what recommendations from that report OWCP is prepared to implement. OWCP plans to reevaluate its approach to measuring customer satisfaction, given the recommendations of your study and our own evolving thoughts about identifying more precisely where and how to focus our efforts at improving customer service. Since we have utilized the global satisfaction data from the current survey as a simple GPRA measure of our customer service goal, we may determine that this survey needs to be continued in some form for that purpose, but we are also considering taking other approaches entirely; for example, surveys that would get at satisfaction with a specific service response at the individual district office level. If we determine that a general survey of the current type should be continued, we will incorporate the recommendations cited below in any enhancement of that survey, and we hope that your office would work with us in that effort.

FEC developed the use of the customer survey as a result of the Executive Order in 1994 on customer service, to evaluate its customers and implement plans to improve service to customers. FEC's Strategic Plan, developed in 1995, recognizes that improving customer service (and hence satisfaction) is a critical issue for this program, and makes customer service improvement one of our key goals and measures. Although the survey we have conducted addresses several different components of service, when the program built its GPRA goals structure, the single overall measure of satisfaction statistic was selected as a simple and concise measure against which to track progress. Nevertheless, the program has continued to utilize the full reports of survey results -- including data on telephone and written communications responsiveness and quality -- to inform its district office staff about areas requiring more attention.

We also utilize other measures of service, such as timeliness of decision-making, bill payment, correspondence and telephone responses, as well as quality measures and informal assessments of complaints received, to evaluate the level of service in the various offices. While we acknowledge that many of the technical and statistical improvements cited in your report would better support this survey and make it more useful, we believe that the data we have derived from our survey are consistent with our

general observations of customer attitudes, and that the moderate improvements it shows over the past three years are generally reflective of our improved service.

You shared several concerns about the procedures used in past FEC customer surveys, including documentation of sampling methods, more focused questions to the customers, pilot testing of the questionnaire itself prior to its redesign, and a more formal statement of work regarding requirements to the contractor. All of these recommendations will be looked at closely. If FEC determines that it will proceed with a customer survey, the recommendations below will be incorporated:

Recommendations on "Survey Design"

We agree with Recommendation #1 that the questionnaire could benefit from being revised to shorten its length, improve the formatting and eliminate duplicate questions.

We agree with Recommendation #2 regarding the formatting of questions to put the like questions together. We would note, however, that OWCP/FEC has received no complaints from claimants through the past three years that there is undue 'burden' in completion of the questionnaires, as your report suggests.

We agree with Recommendation #3 that a pilot test may be useful should we substantially revise the survey in the future.

Recommendation on "Customer Service"

We will review this suggestion, to supplement the use of a survey on customer satisfaction by using focus groups, depending on the availability of funding.

Recommendations on "Sampling"

We agree with Recommendation #1, regarding weighting the sample. It should be noted, however, that OWCP's original design sought to determine satisfaction among each of the different types of claimants. We continue to need that level of specific information to guide our efforts.

We agree with Recommendation #2 to analyze the sample to identify and eliminate any overlap in sample selection from each subgroup.

We agree in general with Recommendation #3 that focusing the analysis of the survey data on the key questions may improve the contractor's report. However, the program believes that analysis of district office level data, while not necessarily statistically valid, may be useful in guiding individual offices' communications plans.

We agree with Recommendation #4 to conduct additional analysis of samples, including: a comparison of the sample to the national claimant universe, using demographic variables and estimation of sampling error.

Recommendations on "Response Rate"

We agree with Recommendation #1 that we seek to hold the contractor to a higher standard for response rates. We will include this in future work statements. However, we anticipate that the cost of requiring such a response rate may be substantially higher. Even using a fixed price contract with a mandated response rate, the OMB goal of 80% may not be attainable. OWCP also notes that it required the 1998 contractor to conduct a telephone survey which measured non-respondents' attitudes. This was not aimed at increasing response rates; this data set was used to determine whether or not the non-respondent population held views similar to those measured for the respondents. As reported in that survey, the two groups had comparable scores, providing increased confidence in the reported statistics.

We agree with Recommendation #2, to add a cover letter from the FEC program to explain the importance of the survey.

We do not agree with Recommendation #3 that an additional copy of the survey itself should be mailed, since the survey is anonymous and there is no record of who are the "non-respondents". To implement this would allow for duplicate submission of the survey by a given respondent (see Recommendation #2 regarding sampling, requiring that we avoid duplicate replies). OWCP has scrupulously maintained the anonymity of the survey respondents, and coding the surveys to allow identification of responses could undermine confidence in that process.

Recommendations on "Survey Operations"

We agree with Recommendation #1 to keep a record of the returned surveys and identify the reason they were returned.

We agree with Recommendation #2 that the time period we use as the basis for drawing the sample should be coordinated with the time frame specified in the questionnaire, and that the questionnaires should be distributed as close as possible to that time frame.

We agree with Recommendation #3 that the full data sets derived from the questionnaire by the contract be provided back to FEC as one of the project deliverables.

Appendix III

Customer Service Questionnaires, 1996-1998

1994

Claimant

Dear Workers' Compensation Claimant:

The Office of Workers' Compensation Programs oversees the administration of the Federal Employees' Compensation Act. Claims are reported directly to FECA district offices located in the major cities in the United States and decisions made on eligibility in those district offices. How well this system works affects individuals like yourself. The Office of Workers' Compensation Programs needs to know how well this system is working in fulfilling its mission.

You are one of a small number of injured workers being asked to give their opinions on these matters. You were drawn from a random sample from injured workers subject to the provisions of the Federal Employees' Compensation Act. If the results are to truly represent the thinking of all injured workers covered by this program, it is important that each questionnaire be completed and returned.

You may be assured of complete confidentiality. The questionnaire has an identification number for mailing purposes only. This is so that we may check your name off the mailing list when your questionnaire is returned. Neither your name nor the name of your employer will ever be placed on the questionnaire.

The results of this study will be used to determine how well the Office of Workers' Compensation Programs is serving you, the customer.

We appreciate your cooperation in completing this questionnaire.

Sincerely,

Thomas M. Markey
Director for Federal
Employees' Compensation

1994

Denial Claims (For identification purposes; not to be placed on survey questionnaire)

DIVISION OF FEDERAL EMPLOYEES' COMPENSATION
CUSTOMER SURVEY

Submission of this information is entirely voluntary and will not be utilized by other government agencies. The primary use of this information will be by the Office of Workers' Compensation Programs to determine how well our customers are being served. The responses provided will have no effect on your entitlement to benefits.

1. Were you treated in a professional and courteous manner by the Department of Labor's FECA district office staff?
☐ Always ☐ Usually ☐ Sometimes
☐ Rarely ☐ Never ☐ Does not apply
2. Did the FECA district office employee who assisted you address all the concerns you raised? ☐ All ☐ Some
☐ Neutral ☐ Few ☐ None ☐ Does not apply
3. Did you receive accurate information when you telephoned the FECA district office? ☐ Very Accurate ☐ Accurate
☐ Neutral ☐ Inaccurate ☐ Very Inaccurate ☐ Does not apply
4. Was the written correspondence that you received from the FECA district office clear and understandable? ☐ Very Clear
☐ Clear ☐ Neutral ☐ Unclear ☐ Very Unclear
☐ Does not apply
5. When you called the FECA district office, was it easy for you to speak directly with a person or leave a voice mail message? ☐ Very Easy ☐ Easy ☐ Neutral ☐ Difficult
☐ Very Difficult ☐ Does not apply
6. If you left a voice mail message, was your call returned promptly?
☐ Very Promptly ☐ Promptly ☐ Neutral ☐ Not promptly
☐ Had To Call Again ☐ Does not apply
7. Did the formal denial notice that you received from the FECA district office clearly explain why your claim was rejected?
☐ Very Clear ☐ Clear ☐ Neutral ☐ Unclear
☐ Very Unclear ☐ Does not apply

-
-
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-

Customer Service Evaluation

In an effort to improve the service we provide to our customers, the Office of Workers' Compensation Programs is conducting this survey. You have been selected at random from a list of individuals who have filed claims with OWCP in the past year. Your response to this questionnaire is entirely voluntary and will be used only by OWCP and no other government agencies. You can remain entirely anonymous in any case. Your participation or responses will have no effect on your entitlement to benefits.

We encourage you to participate so that we can learn how we currently are doing in our relationships with our customers. The OWCP has contracted with a professional research company, the Market Research Bureau, to collect and analyze the surveys.

If you have any questions about this survey, please call Maria Ivancin at the Market Research Bureau at 202-333-4245. Thank you for your cooperation.

- 1a. How would you rate your overall satisfaction with the service that you received from the Department of Labor's Office of Workers' Compensation?

4[] Very satisfied
3[] Somewhat satisfied
2[] Not very satisfied
1[] Not at all satisfied

- 1b. Why do you say that? PLEASE BE SPECIFIC _____

- 2a. What, if anything, about the service did you find particularly positive? PLEASE BE SPECIFIC _____

- 2b. What, if anything, about the service did you find particularly negative? PLEASE BE SPECIFIC _____

3. Please rate your level of satisfaction with each of the following regarding the service that you received.

	Very Satisfied	Somewhat Satisfied	Not Very Satisfied	Not at All Satisfied
a. The ease of understanding the application instructions	4[]	3[]	2[]	1[]
b. Answers to questions you had	4[]	3[]	2[]	1[]
c. Any written correspondence you may have gotten	4[]	3[]	2[]	1[]
d. Communications over the telephone	4[]	3[]	2[]	1[]
e. The case worker's knowledge of your specific case	4[]	3[]	2[]	1[]
f. The case worker's knowledge of and ability to explain rules and regulations	4[]	3[]	2[]	1[]

1996

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4a. Did you call the FECA district office about your claim?

1[] Yes - CONTINUE

2[] No - SKIP TO QUESTION 5

4b. How many times did you call the FECA office? _____ INDICATE # OF TIMES YOU CALLED

4c. How long did it take the FECA office to return your phone calls? (If you made more than one phone call, please indicate about how long it took for each call.)

	First Call	Second Call	Third Call	Fourth Call	Fifth Call	Sixth Call
Did not have to leave message/ spoke with someone when you called	1[]	1[]	1[]	1[]	1[]	1[]
The same day	2[]	2[]	2[]	2[]	2[]	2[]
The next day	3[]	3[]	3[]	3[]	3[]	3[]
2-3 days later	4[]	4[]	4[]	4[]	4[]	4[]
4-5 days later	5[]	5[]	5[]	5[]	5[]	5[]
More than 5 days	6[]	6[]	6[]	6[]	6[]	6[]
Never returned the call	7[]	7[]	7[]	7[]	7[]	7[]

4d. How satisfied were you with how quickly your phone calls were returned?

4[] Very satisfied

3[] Somewhat satisfied

2[] Not very satisfied

1[] Not at all satisfied

5a. Did you send any written correspondence to the FECA district office?

1[] Yes - CONTINUE

2[] No - SKIP TO QUESTION 6

5b. How many times did you write to the FECA office? _____ INDICATE # OF TIMES YOU WROTE

5c. Was the response you received from the FECA office by phone, mail, fax or other means?
CHECK ALL THAT APPLY

1[] Phone

2[] Mail

3[] Fax

4[] Other PLEASE SPECIFY _____

5d. How quickly did you get a response to your written correspondence? (If you sent written correspondence more than once, please indicate how long it took to get a response each time you sent something.)

	First Time	Second Time	Third Time	Fourth Time	Fifth Time	Sixth Time
Within a week	1[]	1[]	1[]	1[]	1[]	1[]
1-2 weeks	2[]	2[]	2[]	2[]	2[]	2[]
3-4 weeks	3[]	3[]	3[]	3[]	3[]	3[]
More than 4 weeks	4[]	4[]	4[]	4[]	4[]	4[]
Never received a response	5[]	5[]	5[]	5[]	5[]	5[]

5e. How satisfied were you with the timeliness of the response to your written correspondence?

4[] Very satisfied

3[] Somewhat satisfied

2[] Not very satisfied

1[] Not at all satisfied

1996

G

- 5f. How satisfied were you with the thoroughness and clarity of the response to your written correspondence? (That is, was the response that you received easy to understand, did it answer the questions or concerns that you had, etc.)

4[] Very satisfied
 3[] Somewhat satisfied
 2[] Not very satisfied
 1[] Not at all satisfied

6. When was the last time that you had any contact with the FECA district office?

1[] Within the last week
 2[] 1-2 weeks ago
 3[] 3-4 weeks ago
 4[] 1-3 months ago
 5[] 4-6 months ago
 6[] 7-12 months ago
 7[] More than a year ago

- 7a. Did you find anything confusing or difficult to understand about the process you had to go through in filing your claim?

1[] Yes - CONTINUE 2[] No - SKIP TO QUESTION 8

- 7b. What was confusing or difficult to understand? PLEASE BE SPECIFIC.

8. How helpful were the people who processed your claim at your employing agency in putting you in contact with the FECA district office?

4[] Very helpful
 3[] Somewhat helpful
 2[] Not very helpful
 1[] Not at all helpful

9. The following questions are about the people that you dealt with at the FECA district office. Please rate the people you dealt with at the FECA district office on each of the following using the scale below.

	Very	Somewhat	Not very	Not at all
a. How <i>helpful</i> were the people you dealt with at the FECA district office?	4[]	3[]	2[]	1[]
b. How <i>pleasant and courteous</i> were the people at the FECA district office?	4[]	3[]	2[]	1[]
c. How <i>knowledgeable about the claims process</i> (i.e., rules and regulations) were the people at the FECA district office?	4[]	3[]	2[]	1[]
d. How <i>knowledgeable about your specific case</i> were the people at the FECA district office?	4[]	3[]	2[]	1[]
e. How <i>accessible</i> were the people at the FECA district office? (That is, were they easy to reach/did they return your phone calls, etc.)	4[]	3[]	2[]	1[]

1996

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10a. Have you received notification of a formal decision about your claim?

1[] Yes - CONTINUE 2[] No - SKIP TO QUESTION 12

10b. Did you understand your rights as they were explained to you when you were notified about the decision?

1[] Did not understand rights - CONTINUE WITH QUESTION 10c
2[] Understood rights as explained - SKIP TO QUESTION 11
3[] Do not remember that rights were explained - SKIP TO QUESTION 11

10c. What did you find difficult to understand about your rights as explained in the notification?
PLEASE BE SPECIFIC

11a. Have you received any payments as a result of your claim?

1[] Yes - CONTINUE 2[] No - SKIP TO QUESTION 12

11b. Has payment of your benefits been prompt?

1[] Yes 2[] No

11c. Have any payments been missed?

1[] Yes - CONTINUE 2[] No - SKIP TO QUESTION 12

11d. Were the missed payments replaced in a timely manner?

1[] Yes 2[] No

12. What, if anything, would you change about the service that you got from the OWCP or the FECA district office? PLEASE BE SPECIFIC

13. Do you have any additional comments?

The following information will help us in our analysis of the data.

14. Are you: 1[] Male 2[] Female

15. What is your age? _____

Thank you for your time and your comments. Please return the questionnaire in the postage-paid envelope provided.

1997

OMB No. 1521-0059
Expires 6-30-00

Customer Service Evaluation

In an effort to improve the service we provide to our customers, the Office of Workers' Compensation Programs (OWCP) is conducting this survey. This survey is to be based only on your direct experience with the Office of Workers' Compensation Programs (OWCP) in the last 12 months. It is not to be based on your experience with the organization you work for or have previously worked for. Nor should it be based on any experience with OWCP more than 12 months ago.

You have been selected at random from a list of individuals who have filed claims with OWCP in the past 12 months. Your response to this questionnaire is entirely voluntary and will be used only by OWCP and no other government agencies. You can remain entirely anonymous in any case. Your participation or responses will have no effect on your entitlement to benefits.

We encourage you to participate so that we can learn how we currently are doing in our relationships with our customers. The OWCP has contracted with a professional research company, the Market Research Bureau, to collect and analyze the surveys. Please complete and return your survey before April 15, 1998. Thank you for your cooperation.

Public Burden Statement: We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any questions regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.

1. How would you rate your overall satisfaction with the service that you received from the Department of Labor's Office of Workers' Compensation within the last 12 months?

- 4 ☐ Very satisfied
3 ☐ Somewhat satisfied
2 ☐ Not very satisfied
1 ☐ Not at all satisfied

- 2a. What, if anything, about the service did you find particularly positive? PLEASE BE SPECIFIC

- 2b. What, if anything, about the service did you find particularly negative? PLEASE BE SPECIFIC

3. Please rate your level of satisfaction with each of the following regarding the service that you received within the last 12 months.

	Very Satisfied	Somewhat Satisfied	Not Very Satisfied	Not at All Satisfied
a. The ease of understanding the application instructions.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
b. Answers to questions you had.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
c. Any written correspondence you may have gotten.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
d. Communications over the telephone.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
e. The claims examiner's knowledge of your specific case.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
f. The claims examiner's knowledge of rules and regulations.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>

1997

4a. Did you call the OWCP district office about your claim within the last 12 months?

- 1 ☐ Yes - CONTINUE
2 ☐ No - SKIP TO QUESTION 5a

4b. How many times did you call the OWCP office within the last 12 months? _____ INDICATE # OF TIMES YOU CALLED

4c. How long did it take the OWCP district office to return your phone calls? (If you made more than one phone call, please indicate about how long it took for each call.)

	First Call	Second Call	Third Call	Fourth Call	Fifth Call	Sixth Call
Did not have to leave message / spoke with someone when you called	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
The same day	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
The next day	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
2-3 days later	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
4-5 days later	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>
More than 5 days	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>	6 <input type="checkbox"/>
Never returned the call	7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>	7 <input type="checkbox"/>

d. How satisfied were you with how quickly the phone calls were returned?

- 4 ☐ Very satisfied
3 ☐ Somewhat satisfied
2 ☐ Not very satisfied
1 ☐ Not at all satisfied

5a. Did you send any written correspondence to the OWCP district office within the last 12 months?

- 1 ☐ Yes - CONTINUE
2 ☐ No - SKIP TO QUESTION 6

5b. How many times did you write to the OWCP district office within the last 12 months? _____ INDICATE # OF TIMES YOU WROTE

5c. Was the response you received from the OWCP office by phone, mail, fax or other means? CHECK ALL THAT APPLY

- 1 ☐ Phone 2 ☐ Mail 3 ☐ Fax 4 ☐ Other PLEASE SPECIFY _____

1997

- 5d. How quickly did you get a response to your written correspondence? (If you sent written correspondence more than once, please indicate how long it took to get a response for each time you sent something.)

	First Time	Second Time	Third Time	Fourth Time	Fifth Time	Sixth Time
Within a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1-2 weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3-4 weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 4 weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Never received a response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- e. How satisfied were you with the timeliness of the response to your written correspondence?

- ☐ 4 Very satisfied
☐ 3 Somewhat satisfied
☐ 2 Not very satisfied
☐ 1 Not at all satisfied

- f. How satisfied were you with the thoroughness and clarity of the response to your written correspondence? (That is, was the response that you received easy to understand, did it answer the questions or concerns that you had, etc.)

- ☐ 4 Very satisfied
☐ 3 Somewhat satisfied
☐ 2 Not very satisfied
☐ 1 Not at all satisfied

When was the last time that you had any contact with the OWCP district office?

- ☐ 1 Within the last week
☐ 2 1-2 weeks ago
☐ 3 3-4 weeks ago
☐ 4 1-3 months ago
☐ 5 4-6 months ago
☐ 6 7-12 months ago
☐ 7 more than a year ago

7. Did you find anything confusing or difficult to understand about the process you had to go through in filing your claim?

- ☐ 1 Yes
☐ 2 No

8. How helpful were the people who processed your claim at your employing agency in putting you in contact with the OWCP district office?

- ☐ 4 Very helpful
☐ 3 Somewhat helpful
☐ 2 Not very helpful
☐ 1 Not at all helpful

1997

9. The following questions are about the people that you dealt with at the OWCP district office within the last 12 months. Please rate the people you dealt with at the OWCP district office on each of the following using the scale below.

	Very	Somewhat	Not very	Not at all
a. How <i>helpful</i> were the people you dealt with at the OWCP district office?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
b. How <i>pleasant and courteous</i> were the people at the OWCP district office?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
c. How knowledgeable about the claims process (i.e., rules and regulations) were the people at the OWCP district office?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
d. How knowledgeable about your specific case were the people at the OWCP district office?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
e. How <i>accessible</i> were the people at the OWCP district office? (That is, were they easy to reach/ did they return your phone calls, etc.)	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>

- 10a. Have you received notification of a formal decision about your claim?

1 ☐ Yes - CONTINUE 2 ☐ No - SKIP TO QUESTION 11

- 10b. Did you understand your rights as they were explained to you when you were notified about the decision?

1 ☐ Did not understand the rights
 2 ☐ Understood rights as explained
 3 ☐ Do not remember that rights were explained

11. Do you have any additional comments regarding the customer service provided to you by telephone or written correspondence in the last 12 months?

The following information will help us in our analysis of the data.

12. Are you:

1 ☐ Male
 2 ☐ Female

13. What is your age? _____

Thank you for your time and comments. Please return the questionnaire in the postage-paid envelope provided.

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1998

OMB No. 1223-0029
Expires: 6-30-00

Customer Service Evaluation

In an effort to improve the service we provide to our customers, the Office of Workers' Compensation Programs (OWCP) is conducting this survey. This survey is to be based only on your direct experience with the Office of Workers' Compensation Programs (OWCP) in the last 12 months. It is not to be based on your experience with the organization you work for or have previously worked for. Nor should it be based on any experience with OWCP more than 12 months ago.

You have been selected at random from a list of individuals who have filed claims with OWCP in the past 12 months. Your response to this questionnaire is entirely voluntary and will be used only by OWCP and no other government agencies. You can remain entirely anonymous in any case. Your participation or responses will have no effect on your entitlement to benefits.

We encourage you to participate so that we can learn how we currently are doing in our relationships with our customers. The OWCP has contracted with a professional research company, the Market Research Bureau, to collect and analyze the surveys. Please complete and return your survey before April 15, 1998. Thank you for your cooperation.

Public Burden Statement: We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any questions regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.

1. How would you rate your overall satisfaction with the service that you received from the Department of Labor's Office of Workers' Compensation in the last 12 months?

4 ☐ Very satisfied
3 ☐ Somewhat satisfied
2 ☐ Not very satisfied
1 ☐ Not at all satisfied

- 2a. What, if anything, about the service did you find particularly positive? PLEASE BE SPECIFIC

- 2b. What, if anything, about the service did you find particularly negative? PLEASE BE SPECIFIC

3. Please rate your level of satisfaction with each of the following regarding the service that you received within the last 12 months.

	Very Satisfied	Somewhat Satisfied	Not Very Satisfied	Not at All Satisfied
a. The ease of understanding the application instructions.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
b. Answers to questions you have.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
c. Any written correspondence you may have gotten.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
d. Communications over the telephone.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
e. The claims examiner's knowledge of your specific case.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
f. The claims examiner's knowledge of rules and regulations.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>

1998

- 4a. Did you call the OWCP district office about your claim within the last 12 months?
- 1 ☐ Yes - CONTINUE
2 ☐ No - SKIP TO QUESTION 5a
- 4b. How many times did you call the OWCP office within the last 12 months? _____ INDICATE # OF TIMES YOU CALLED
- 4c. How long did it take the OWCP district office to return your phone calls? (If you made more than one phone call, please indicate about how long it took for each call.)
- | | First
Call | Second
Call | Third
Call | Fourth
Call | Fifth
Call | Sixth
Call |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Did not have to leave message / spoke
with someone when you called | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| The same day | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| The next day | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 2-3 days later | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 4-5 days later | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| More than 5 days | 6 <input type="checkbox"/> | 6 <input type="checkbox"/> | 6 <input type="checkbox"/> | 6 <input type="checkbox"/> | 6 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| Never returned the call | 7 <input type="checkbox"/> | 7 <input type="checkbox"/> | 7 <input type="checkbox"/> | 7 <input type="checkbox"/> | 7 <input type="checkbox"/> | 7 <input type="checkbox"/> |
- 4d. How satisfied were you with how quickly the phone calls were returned?
- 4 ☐ Very satisfied
3 ☐ Somewhat satisfied
2 ☐ Not very satisfied
1 ☐ Not at all satisfied
- 5a. Did you send any written correspondence to the OWCP district office within the last 12 months?
- 1 ☐ Yes - CONTINUE
2 ☐ No - SKIP TO QUESTION 6
- 5b. How many times did you write to the OWCP district office within the last 12 months? _____ INDICATE # OF TIMES YOU WROTE
- 5c. Was the response you received from the OWCP office by phone, mail, fax or other means? CHECK ALL THAT APPLY
- 1 ☐ Phone 2 ☐ Mail 3 ☐ Fax 4 ☐ Other PLEASE SPECIFY _____
- 5d. How quickly did you get a response to your written correspondence? (If you sent written correspondence more than once, please indicate how long it took to get a response for each time you sent something.)
- | | First
Time | Second
Time | Third
Time | Fourth
Time | Fifth
Time | Sixth
Time |
|---------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Within a week | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| 1-2 weeks | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 3-4 weeks | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| More than 4 weeks | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Never received a response | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> |

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5e. How satisfied were you with the timeliness of the response to your written correspondence?

- 4 ☐ Very satisfied
 3 ☐ Somewhat satisfied
 2 ☐ Not very satisfied
 1 ☐ Not at all satisfied

5f. How satisfied were you with the thoroughness and clarity of the response to your written correspondence? (That is, was the response that you received easy to understand, did it answer the questions or concerns that you had, etc.)

- 4 ☐ Very satisfied
 3 ☐ Somewhat satisfied
 2 ☐ Not very satisfied
 1 ☐ Not at all satisfied

6. When was the last time that you had any contact with the OWCP district office?

- 1 ☐ Within the last week
 2 ☐ 1-2 weeks ago
 3 ☐ 3-4 weeks ago
 4 ☐ 1-3 months ago
 5 ☐ 4-6 months ago
 6 ☐ 7-12 months ago
 7 ☐ more than a year ago

7. Did you find anything confusing or difficult to understand about the process you had to go through in filing your claim?

- 1 ☐ Yes
 2 ☐ No

8. How helpful were the people who processed your claim at your employing agency in putting you in contact with the OWCP district office?

- 4 ☐ Very helpful
 3 ☐ Somewhat helpful
 2 ☐ Not very helpful
 1 ☐ Not at all helpful

9. The following questions are about the people that you dealt with at the OWCP district office within the last 12 months. Please rate the people you dealt with at the OWCP district office on each of the following using the scale below.

	Very	Somewhat	Not very	Not at all
a. How <i>helpful</i> were the people you dealt with at the OWCP district office?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
b. How <i>pleasant and courteous</i> were the people at the OWCP district office?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
c. How <i>knowledgeable</i> about the claims process (i.e., rules and regulations) were the people at the OWCP district office?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
d. How <i>knowledgeable</i> about your specific case were the people at the OWCP district office?	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
e. How <i>accessible</i> were the people at the OWCP district office? (That is, were they easy to reach/ did they return your phone calls, etc.)	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>

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1998

10a. Have you received notification of a formal decision about your claim?

- 1 ☐ Yes - CONTINUE
2 ☐ No - SKIP TO QUESTION 12

10b. Did you understand your rights as they were explained to you when you were notified about the decision?

- 1 ☐ Did not understand the rights
2 ☐ Understood rights as explained
3 ☐ Do not remember that rights were explained

11a. Have you received any payments as a result of your claim?

- 1 ☐ Yes - CONTINUE
2 ☐ No - SKIP TO QUESTION 12

11b. Has payment of your benefits been prompt?

- 1 ☐ Yes
2 ☐ No

11c. Have any payments been missed?

- 1 ☐ Yes - CONTINUE
2 ☐ No - SKIP TO QUESTION 12

11d. Were the missed payments replaced in a timely manner?

- 1 ☐ Yes
2 ☐ No

12. Do you have any additional comments regarding the customer service provided to you by telephone or written correspondence in the last 12 months?

The following information will help us in our analysis of the data.

13. Are you:

- 1 ☐ Male
2 ☐ Female

14. What is your age? _____

Thank you for your time and comments. Please return the questionnaire in the postage-paid envelope provided.

Mr. HORN. Now, in this strategic plan, which was new to all of the executive branch and was asked for it 5 years before they had to do it—and I want to go through that now with the Inspector General. I hope you have a copy of that, do you, of their strategic plan?

Ms. DALTON. I don't have it with me.

Mr. HORN. Can we give Ms. Dalton a copy of that? I think the staff here has it.

What I want to do is just go through those charts that you have in your appendix, and I would like the Inspector General to take a look at those and see what they could provide. Because you are doing the right thing in the sense of looking at the goals you should achieve in a matter of time and dealing with the cases and so forth.

The gripe I have heard from hundreds of Federal injured workers is that, too often, they don't get approval to get the medical therapy that they need if they are going to get back to work and that, I think, we have just got to focus on, who sits on those appeals and who lets them go. I think that is one of the things we need to deal with.

Here on the Department of Labor's Strategic Goal 2, A Secure Workforce; and your Outcome Goal, Protect Worker Benefits. Now, you say fiscal year 1999 funding, not known. Cost accounting for discreet GPRA, which is the Government Performance and Results Act, which we take very seriously up here—I think we have to take a look at these in terms of the Inspector General for Labor as a whole and say: Is there something else that can be done here? Does what you want to do in your strategic goals really relate to what your fiscal plan is when you send it over to OMB and the President as to the resources you need?

So I just think we need a little analysis of that. Is this just talk and hokum or is the money there? As they say, where's the money? And we need to know that. And we need to know if the money was given. Some agencies never put it on computers, they put it on people. Others put it only on computers and don't put it on people. So some of what I would like to do is just have your two offices work it out, put it in the record at this point.

[The information referred to follows:]

APPENDIX

OFFICE OF WORKERS' COMPENSATION PROGRAMS**PROGRAM PERFORMANCE REVIEW
(FISCAL QUARTERS 1/99 AND 2/99)**Performance Overview

The Office of Workers' Compensation Programs mitigates the financial burden on certain workers, or their dependents or survivors, resulting from work-related injury, disease, or death, through the provision of wage replacement and cash benefits, medical treatment, vocational rehabilitation, and other benefits. OWCP will provide individuals who experience work-related injuries the best and most cost-effective assistance and services possible. As the country's largest self-insured employer, the Federal government is uniquely situated to find the best ways to take care of people affected by workplace injuries, and OWCP can be a laboratory for excellence in the field of workers' compensation.

The Government Performance and Results Act is being implemented in a thoughtful and organic way in OWCP. Building upon OWCP's long performance measurement history, a FECA union/management partnership team identified strategic goals consistent with the OWCP mission and which would increase program impact. Multiple process reengineering, programmatic, and high technology initiatives, begun in the early 1990's, were organized in support of the strategic goals. GPRA goals were aligned with performance objectives in OWCP's program operational plans and incorporated into the performance agreements of national office, regional and field managers. GPRA performance evaluations, based on evolving data systems, are conducted at frequent intervals alongside OWCP's regular Quarterly Review and Analysis and Accountability and Management Review processes.

Midway through FY 1999, OWCP is meeting or exceeding the three performance goals included in the DOL Annual Performance Plan. We are also meeting or exceeding the five additional performance goals included in the ESA Annual Performance Plan, where measurements are available.

The most indicative, critical goal for OWCP is the reduction of the number of days workers are away from their jobs due to work injury-related disabilities. This goal is a key measure of the impact of work-related injuries and central to OWCP's return-to-work emphasis. FECA's Quality Case Management program to intervene early in new injury cases has reduced lost production days (LPD) to an average 177 days for cases measured in FY 1999. This represents a reduction of 18 days since the fourth quarter of 1996, when first measurements were taken.

Since FY 1994, OWCP has surveyed Federal civilian employees, who are/were disabled by on-the-job injury or illness. In response to the survey results, the program developed a Customer Service Plan. The program has also developed corrective action plans to deal with customers service shortcomings. Customer satisfaction survey scores have improved.

Customer service improvement, in the form of processing timeliness and decision quality, is a second strategic emphasis in FECA. Decision quality is emphasized in the Accountability Review process, where each district office is given a Quality Index score. Our work with the Federal employing agencies has resulted in more timely filing of new injury reports and is opening the way to providing assistance much sooner following occurrence of injury.

Fiscal integrity, a third strategic emphasis in FECA, is being addressed with a battery of cost-containment and fiscal controls. Medical fee schedules, computer software assisted bill review, and strengthened disability case review are improving results in this area.

Fee schedules on outpatient and physician services saved \$93.7 million against amounts billed in FY 1998. New fee schedules, effective January 1999, are expected to save 5% of inpatient hospital and pharmacy billings in FY 1999. Also in FY 1999, OWCP is developing a medical bill review process to catch improper billings before they are paid. This automation-assisted process will detect improperly coded bills, (such as bills "unbundled" into component services to enhance revenue), duplication, overuse or inappropriate use of services to treat given conditions, and other abuses.

Performance measurement has been refined since the team's initial efforts. Initial GPRA performance objectives focused on program priorities and strategic direction. OWCP is working to include more of its core activities in result-based measurement. OWCP is also working to make improvements wherever we have established preliminary or interim baselines, where industry benchmarks are suitable, or where goals and supporting data are not sufficiently comprehensive. For example, in FY 2000 OWCP will redefine the baseline, goal and method of measurement for time lost during the Continuation of Pay (COP) period, to accomplish the goal of Federal Worker 2000 to reduce overall lost production days for all injuries. For this, we will begin to collect data on COP usage from Federal agencies.

DOL STRATEGIC GOAL 2: A Secure Workforce DOL OUTCOME GOAL (2.2): Protect Worker Benefits
<p>PERFORMANCE GOAL (2.2E): Return Federal employees to work following an injury as early as appropriate, indicated by a 6% reduction from the baseline in production days lost due to disability for cases in the Quality Case Management (QCM).</p> <p>INDICATOR: Average number of days lost due to disability for cases in QCM.</p> <p>BASELINE: Interim baseline for Quality Case Management cases only: FY 1997 actual – 189 workdays.</p> <p>RATIONALE FOR SELECTING MEASURE:</p> <ul style="list-style-type: none"> • Production days lost due to disability is a key indicator of the degree of impact of work-related injuries on injured workers. • The primary focus of FECA strategic planning is to lessen the impact of injuries. • Average LPD measures the outcome of FECA's early case management and vocational rehabilitation programs to speed recovery from injury and return to work. <p>FY 1999 FUNDING: Not known. (Cost accounting for discreet GPRA activities is not currently available in DOL.)</p>
<p>FQ 2/99 STATUS</p> <p>PROGRESS:</p> <p><u>We are currently meeting the goal.</u> Average LPD was 177 days for QCM cases measured in Quarters 1 and 2, slightly better than the goal of 178 days.</p> <p>COMMENTS/ISSUES:</p> <ul style="list-style-type: none"> • The 12-day reduction from the FY 1997 LPD baseline represents a compensation benefit savings of over \$3.3 million for those cases measured in FY 1999. • Through FY 2000, the interim baseline and measurement focuses on the average number of production days lost for cases in only QCM cases. Beginning in FY 2000, a baseline for all injuries will be established. • Performance for this goal is illustrated in attached graph.

APPENDIX

OFFICE OF WORKERS' COMPENSATION PROGRAMS**PROGRAM PERFORMANCE REVIEW
(FISCAL QUARTERS 1/99 AND 2/99)**Performance Overview

The Office of Workers' Compensation Programs mitigates the financial burden on certain workers, or their dependents or survivors, resulting from work-related injury, disease, or death, through the provision of wage replacement and cash benefits, medical treatment, vocational rehabilitation, and other benefits. OWCP will provide individuals who experience work-related injuries the best and most cost-effective assistance and services possible. As the country's largest self-insured employer, the Federal government is uniquely situated to find the best ways to take care of people affected by workplace injuries, and OWCP can be a laboratory for excellence in the field of workers' compensation.

The Government Performance and Results Act is being implemented in a thoughtful and organic way in OWCP. Building upon OWCP's long performance measurement history, a FECA union/management partnership team identified strategic goals consistent with the OWCP mission and which would increase program impact. Multiple process reengineering, programmatic, and high technology initiatives, begun in the early 1990's, were organized in support of the strategic goals. GPRA goals were aligned with performance objectives in OWCP's program operational plans and incorporated into the performance agreements of national office, regional and field managers. GPRA performance evaluations, based on evolving data systems, are conducted at frequent intervals alongside OWCP's regular Quarterly Review and Analysis and Accountability and Management Review processes.

Midway through FY 1999, OWCP is meeting or exceeding the three performance goals included in the DOL Annual Performance Plan. We are also meeting or exceeding the five additional performance goals included in the ESA Annual Performance Plan, where measurements are available.

The most indicative, critical goal for OWCP is the reduction of the number of days workers are away from their jobs due to work injury-related disabilities. This goal is a key measure of the impact of work-related injuries and central to OWCP's return-to-work emphasis. FECA's Quality Case Management program to intervene early in new injury cases has reduced lost production days (LPD) to an average 177 days for cases measured in FY 1999. This represents a reduction of 18 days since the fourth quarter of 1996, when first measurements were taken.

Since FY 1994, OWCP has surveyed Federal civilian employees, who are/were disabled by on-the-job injury or illness. In response to the survey results, the program developed a Customer Service Plan. The program has also developed corrective action plans to deal with customers service shortcomings. Customer satisfaction survey scores have improved.

Customer service improvement, in the form of processing timeliness and decision quality, is a second strategic emphasis in FECA. Decision quality is emphasized in the Accountability Review process, where each district office is given a Quality Index score. Our work with the Federal employing agencies has resulted in more timely filing of new injury reports and is opening the way to providing assistance much sooner following occurrence of injury.

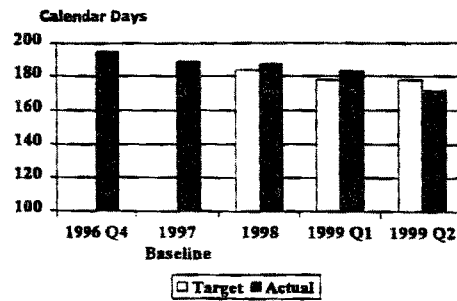
Fiscal integrity, a third strategic emphasis in FECA, is being addressed with a battery of cost-containment and fiscal controls. Medical fee schedules, computer software assisted bill review, and strengthened disability case review are improving results in this area.

Fee schedules on outpatient and physician services saved \$93.7 million against amounts billed in FY 1998. New fee schedules, effective January 1999, are expected to save 5% of inpatient hospital and pharmacy billings in FY 1999. Also in FY 1999, OWCP is developing a medical bill review process to catch improper billings before they are paid. This automation-assisted process will detect improperly coded bills, (such as bills "unbundled" into component services to enhance revenue), duplication, overuse or inappropriate use of services to treat given conditions, and other abuses.

Performance measurement has been refined since the team's initial efforts. Initial GPRA performance objectives focused on program priorities and strategic direction. OWCP is working to include more of its core activities in result-based measurement. OWCP is also working to make improvements wherever we have established preliminary or interim baselines, where industry benchmarks are suitable, or where goals and supporting data are not sufficiently comprehensive. For example, in FY 2000 OWCP will redefine the baseline, goal and method of measurement for time lost during the Continuation of Pay (COP) period, to accomplish the goal of Federal Worker 2000 to reduce overall lost production days for all injuries. For this, we will begin to collect data on COP usage from Federal agencies.

<p align="center">DOL STRATEGIC GOAL 2: A Secure Workforce DOL OUTCOME GOAL (2.2): Protect Worker Benefits</p>
<p>PERFORMANCE GOAL (2.2E): Return Federal employees to work following an injury as early as appropriate, indicated by a 6% reduction from the baseline in production days lost due to disability for cases in the Quality Case Management (QCM).</p> <p>INDICATOR: Average number of days lost due to disability for cases in QCM.</p> <p>BASELINE: Interim baseline for Quality Case Management cases only: FY 1997 actual – 189 workdays.</p> <p>RATIONALE FOR SELECTING MEASURE:</p> <ul style="list-style-type: none"> • Production days lost due to disability is a key indicator of the degree of impact of work-related injuries on injured workers. • The primary focus of FECA strategic planning is to lessen the impact of injuries. • Average LPD measures the outcome of FECA's early case management and vocational rehabilitation programs to speed recovery from injury and return to work. <p>FY 1999 FUNDING: Not known. (Cost accounting for discrete GPRA activities is not currently available in DOL.)</p>
<p>FQ 2/99 STATUS</p> <p>PROGRESS:</p> <p><u>We are currently meeting the goal.</u> Average LPD was 177 days for QCM cases measured in Quarters 1 and 2, slightly better than the goal of 178 days.</p> <p>COMMENTS/ISSUES:</p> <ul style="list-style-type: none"> • The 12-day reduction from the FY 1997 LPD baseline represents a compensation benefit savings of over \$3.3 million for those cases measured in FY 1999. • Through FY 2000, the interim baseline and measurement focuses on the average number of production days lost for cases in only QCM cases. Beginning in FY 2000, a baseline for all injuries will be established. • Performance for this goal is illustrated in attached graph.

Performance Goal 2.2E

Reduce Federal Employees' Lost Production Days

1/ Average Calendar Days nationwide measured within the first year from the date wage loss compensation began in Quality Case Management cases only.

**DOL MANAGEMENT COUNCIL
PROGRAM PERFORMANCE REVIEW
(FISCAL QUARTERS 1/99 & 2/99)**

DEPARTMENTAL ANNUAL PERFORMANCE PLAN: STATUS OF PERFORMANCE MEASURES

**DOL STRATEGIC GOAL 2: A Secure Workforce
DOL OUTCOME GOAL (2.2): Protect Worker Benefits**

PERFORMANCE GOAL (2.2F): Produce \$5.7 million in savings in the Federal Employees' Compensation Act (FECA) Program by expanding the Periodic Roll Management project that reviews the continued eligibility of long-term beneficiaries.

INDICATOR: The amount of compensation benefit savings from resolved long-term (PRM) disability cases.

BASELINE: Savings produced in base year prior to PRM project start-up in each office.

RATIONALE FOR SELECTING MEASURE:

- Long-term disability (periodic roll) cases represent the majority of FECA compensation costs and management of these cases is highly cost-effective.
- PRM case reviews identify workers whose disability has lessened and who may benefit from the program's return-to-work assistance.
- PRM case reviews determine continuing benefit entitlement and ensure proper levels of benefit payments. This supports the fiscal integrity of the FECA Special Benefits Fund.
- Dollar savings resulting from PRM decisions indicate the production and efficiency levels of the case review activity.

FY 1999 FUNDING: Not known. (Cost accounting for discreet GPRA activities is not currently available in DOL.)

FQ 2/99 STATUS

PROGRESS:

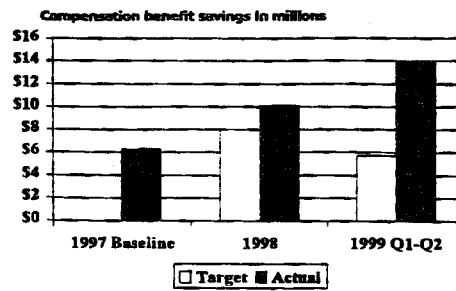
The goal has been exceeded. Benefit savings for FY 1999 from PRM case review actions made between October 1, 1998 and March 31, 1999 are \$13.9 million. This is more than double the savings goal for the full fiscal year.

As discussed in the FY 1999 and FY 2000 Annual Performance Plans, Periodic Roll Management was expanded to all district offices in FY 1999 and made a permanent program activity. The PRM savings calculation method has been revised to more accurately account for this change.

COMMENTS/ISSUES:

- PRM savings were previously calculated by compared total savings from benefit adjustments and terminations on all cases, both PRM and non-PRM, in each district office, to total savings produced in the year prior to PRM start-up in that office. With PRM expansion, PRM savings are now calculated by comparing total savings from both QCM and PRM case actions to non-PRM case action savings in FY 1998 (the baseline year prior to PRM expansion).
- Performance for this goal is illustrated in attached graph.

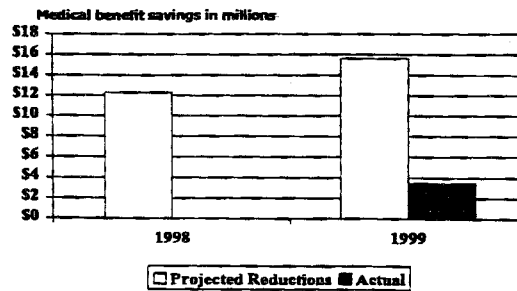
Performance Goal 2.2F
Increase FECA Periodic Roll Management Savings



1/ The performance calculation has been revised to more accurately account for the expansion of PRM case review to a permanent FECA activity. Baseline is reestablished as actual FY 1998 benefit reductions in non-PRM cases.

DOL STRATEGIC GOAL 2: A Secure Workforce DOL OUTCOME GOAL (2.2): Protect Worker Benefits
<p>PERFORMANCE GOAL (2.2G): In the Federal Employees' Compensation Act (FECA) Program, save 5% versus amounts billed for pharmacy and inpatient hospital services and 3% versus amounts billed for physician and other professional medical services through review of bills prior to payment to identify improper use by the medical provider.</p> <p>INDICATOR: Amounts paid versus amounts billed for hospital inpatient services, drugs, and physician/professional services.</p> <p>BASELINE: Amounts billed for hospital in-patient, pharmacy, and physician/professional services in FY 1999. (Baseline is the amount billed in the measurement year.)</p> <p>RATIONALE FOR SELECTING MEASURE:</p> <p style="padding-left: 40px;">This goal supports fiscal management and the integrity of the FECA Special Fund by gauging the effectiveness two new medical cost control initiatives: a fee schedule for pharmacy services and for inpatient hospital services, and by identifying and correcting for abusive billing practices.</p> <p>FY 1999 FUNDING: Not known. (Cost accounting for discrete GPRA activities is not currently available in DOL.)</p>
<p>FQ 2/99 STATUS</p> <p>PROGRESS:</p> <p><u>The goal is on target to be met or exceeded by the end of FY 1999.</u> In January 1999 new regulations extended Fee Schedules to inpatient hospital and pharmacy services. These services accounted for \$81.4 million and \$41.2 million, respectively, of the total \$476 million paid for medical benefits in FY 1998. Preliminary results through March 1999 show that inpatient hospital billed amounts were reduced by 23% under the fee schedule, and pharmacy billings by 12%.</p> <p>For its new automated bill review Quality Assurance program, FECA is currently adapting medical bill editing software designed to identify medical providers' duplicative and abusive billing practices. FECA is also in the process of hiring specialized staff who will evaluate questionable bills identified by the system and resolve them before authorizing payment. Additionally, FECA is developing a Quality Assurance Program to ensure a high level of accuracy in the resolution of complex bills. Implementation in all district offices is scheduled by the end of the fiscal year.</p> <p>COMMENTS/ISSUES:</p> <ul style="list-style-type: none"> • Even though the medical bill review process will not be implemented until late in FY 1999, the savings generated by the new fee schedules will far exceed the total savings projected for both initiatives. • Performance for this goal is illustrated in attached graph.

Performance Goal 2.2G
Increase FECA Medical Cost Reduction Savings



1/ FY 1998 target: Reduce 10% of amounts billed for Inpatient Hospital (IP) and Pharmacy services.

2/ FY 1999 target: Reduce 5% of amounts billed for IP and Pharmacy services through fee schedules and 3% of amounts billed for physician services through medical bill review.

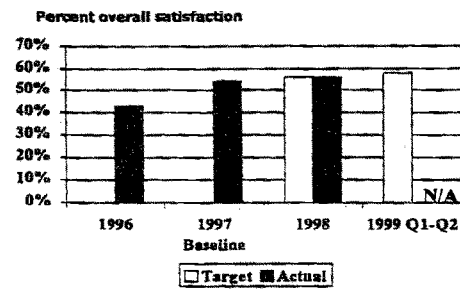
3/ Implementing regulations for the IP and Pharmacy fee schedules were originally planned for FY 1998 but did not go into effect until January 1999.

4/ Testing of bill review software and new staff hiring has delayed implementation of the Medical Bill Review (Quality Assurance) program until the latter part of FY 1999.

5/ Actual savings did not begin until January 4, 1999; despite implementation delays, the program expects to meet its annual target by the end of the fiscal year.

<p align="center">DOL STRATEGIC GOAL 2: A Secure Workforce</p> <p>DOL OUTCOME GOAL (2.2): Protect Worker Benefits</p>
<p>PERFORMANCE GOAL (P.6): Increase customer satisfaction with the OWCP Federal Employees' Compensation Act (FECA) Program by 4 percentage points.</p> <p>INDICATOR: Customer survey results indicating satisfaction.</p> <p>BASELINE: FY 1997: 54% Overall satisfaction</p> <p>RATIONALE FOR SELECTING MEASURE:</p> <ul style="list-style-type: none"> • FECA is a service-delivery program and improvement of claims filing assistance, communication responsiveness, processing timeliness, and other customer services are important strategies in lessening the impact of work-related injuries. • Customer satisfaction surveys are useful in identifying service deficiencies. <p>FY 1999 FUNDING: Not known. (Cost accounting for discreet GPRA activities is not currently available in DOL.)</p>
<p>FQ 2/99 STATUS</p> <p>PROGRESS:</p> <p><u>Data is not yet available for FY 1999.</u> The customer survey of FY 1998 reported a 56% overall satisfaction with FECA services. FECA expects to select a contractor and issue the FY 1999 survey by May 1. Results will be available by September 30, 1999.</p> <p>COMMENTS/ISSUES:</p> <ul style="list-style-type: none"> • Performance for this goal is illustrated in attached graph.

ESA Performance Goal P.6
Increase FECA Customer Satisfaction



I/ FY 1999 customer survey results will not be available until September, 1999.

DOL STRATEGIC GOAL 2: A Secure Workforce
DOL OUTCOME GOAL (2.2): Protect Worker Benefits

PERFORMANCE GOAL (P.9): Increase the timeliness of notice of injury submission by employing Federal agencies under the FECA by 10 percentage points.

INDICATOR: Average time between agency supervisors' authorization and receipt of claim forms by FECA.

BASELINE: FY 1997 average: 41%.

RATIONALE FOR SELECTING MEASURE:

- Agencies' prompt injury reporting supports FECA program goals to intervene earlier in new injury cases to speed recovery and return to work and, overall, to provide better services to injured workers.
- A major FECA program strategy is to promote improvement of the Federal employing agencies' role in administering the FECA, assisting workers, and containing costs.
- This measure targets the improvement of new injury processing timeliness by the employers.

FY 1999 FUNDING: Not known. (Cost accounting for discrete GPRA activities is not currently available in DOL.)

FQ 2/99 STATUS

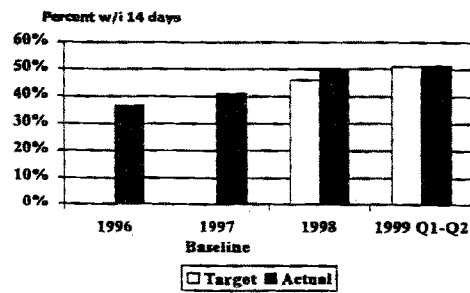
PROGRESS:

The goal is currently being met. Overall average filing time of Notice of Injury reports improved in the first two quarters of FY 1999 to 51.3 percent within 14 days, or 10.3 percentage points above the baseline.

COMMENTS/ISSUES:

- OWCP had hoped to initiate electronic transmission of claims from at least 2 or 3 major agencies, thereby increasing timeliness. To date, however, no agency has completed the work needed on their systems to send claims electronically.
- Performance for this goal is illustrated in attached graph.

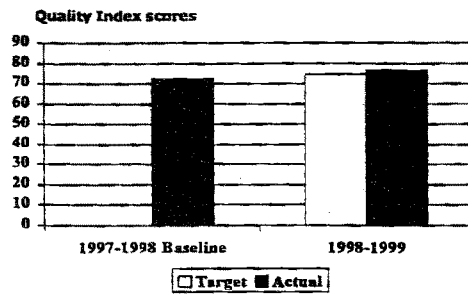
ESA Performance Goal P.9
Increase Federal Employers'
Notice of Injury Timeliness



1/ Average percentage of Notice of Injury reports received within 14 calendar days from all Federal employing agencies.

<p align="center">DOL STRATEGIC GOAL 2: A Secure Workforce</p> <p>DOL OUTCOME GOAL (2.2): Protect Worker Benefits</p>
<p>PERFORMANCE GOAL (P.10): Improve the quality of FECA claims adjudication by 2%.</p> <p>INDICATOR: Nationwide average of Quality Index</p> <p>BASELINE: Quality Index results for FY 1997/1998: 72.5</p> <p>RATIONALE FOR SELECTING MEASURE:</p> <ul style="list-style-type: none"> • This indicator measures the accuracy of claims decisions affecting basic entitlement to benefits. • The goal strengthens program integrity and service delivery. <p>FY 1999 FUNDING: Not known. (Cost accounting for discreet GPRA activities is not currently available in DOL.)</p>
<p>FQ 2/99 STATUS</p> <p>PROGRESS:</p> <p><u>The goal is currently being exceeded.</u> The Quality Index average through the 2nd Quarter is 76.4 and above the FY 1999 target of 74.5.</p> <p>COMMENTS/ISSUES:</p> <ul style="list-style-type: none"> • The Quality Index score consists of the average of twelve individual district office index scores from accountability reviews conducted over a two-year period: six scores from the fiscal year prior to, and six scores within, the reporting year (eg 1998 - 1999). The score through the 2nd Quarter, 1999 consists of seven of the twelve scores planned for the FY 1999 performance period. • Performance for this goal is illustrated in attached graph.

ESA Performance Goal P.10

Increase FECA Adjudication Quality

1/ FY '97-'98 baseline consists of average of twelve individual district office QI scores. Six different offices are scored in each fiscal year.

2/ FY '98-'99 result consists of seven district offices scored to date.

Mr. HORN. I think the question raised by Beth Balen, administrator of the Anchorage Fracture and Orthopedic Clinic, is a very good one. To what degree is the power there for the Office of Workers' Compensation Programs to adjust based on cost of living? San Francisco is a pretty high living place. Seattle, we know is; certainly Alaska is.

Do you have the authority to adapt those to the point, Ms. Balen, made in terms of things they just have to write off because it isn't reasonable in terms of their own economy?

Mr. HALLMARK. Yes, Mr. Chairman. The OWCP fee schedule is, in the case for the Anchorage institution, is a relative value fee schedule which we adopted based on—originally based on the Washington State Workers' Compensation Program System and subsequently modified to follow that used for the Medicare program as established by the Health Care Financing Administration. It is geographically based. That is to say, there is a component of the system that takes into account cost of living, cost of business, cost of real estate, et cetera, in the different geographical regions.

We are aware that some States have higher fee schedules than the OWCP schedule; others have lower. Our schedule, at least at the last review we did, fell almost exactly in the middle. I think there are 23 States below and 26 or 27 States higher. So we have attempted to be—to address geographical issues.

Obviously, in the case of Alaska, what we are hearing today is that, from the perspective of at least this provider, set of providers, our schedule is too low for that State. It is something that is a part of our regulatory structure. We can look at it to determine whether there is a need for adjustment in that regard, and we will do that.

Mr. HORN. Another point Ms. Balen made, which makes sense to me, is easier access to claim payment office. What are we doing on that front?

Mr. HALLMARK. If by that she is referring to the issue of telephone calls and of calling in to address ways of resolving problems, we have a whole series of things we are trying to do to accomplish exactly that.

I didn't quite get through my statement, but it addresses some of the issues that we are trying to work on now in terms of improved communication systems, improved technology. We're moving to a fully electronic world which we believe will have a tremendous impact on customer service.

One of the problems, and cited by some of the panel members this morning, has been that keeping track of millions of pages of paper is a very difficult task. We believe that an imaging system, which we are currently building and expect to implement in 19—I'm sorry, fiscal year 2000 will greatly improve our ability to handle a wide range of these issues and especially medical bills.

All of our offices have communication plans. All are trying to work on improving the access to telephones. We have, I believe, in almost every office, if not every office, ways for individuals to call and receive an individual response. Sometimes, as we have seen today, that doesn't work. We're obviously working hard to improve it.

Mr. HORN. One of the questions that came up was the difficulty of tracking a case if you did not have the case number. Isn't there

a way to solve that with a master index by name and the last four digits in the Social Security number or something like that?

Mr. HALLMARK. Mr. Chairman, we have that. I think in the vast majority of cases, the problems that Ms. Balen was referring to, the Federal agency hasn't sent us the claim. If they haven't sent us the claim, there's nothing for us to interface with. We don't have an electronic connection to the Department of the Interior or the Forest Service to find out information about an individual who has been injured. It is only when the notice of injury comes to us that we can create that electronic record with the name, with the case number, with other identifiers.

Mr. HORN. On that point, suppose an agency doesn't give them the forms? We had testimony to that effect. And certainly, when I met with a number of Federal injured workers, and it has been mentioned already this morning, a lot of them are U.S. Postal Service employees, they couldn't even get the form out of their personnel office. Can't they apply to your agency and get the forms if we have got the post office in parts of the country refusing to recognize there's a problem here?

Mr. HALLMARK. Well, we are certainly aware of the legal requirement that Federal agencies have to do this work and to do it with speed, and where we see—where we have evidence that is presented to us that, in fact, agencies are knowingly restricting or obstructing this program, we take action, and we take it right to the top of the agency to try to get it attention and get the problem solved. In fact, our IG conducted several years ago a joint study with the Inspection Service of the Postal Service to address and try to pinpoint exactly that kind of problem. So we are anxious to address that kind of issue, and we do.

I would note, however, that oftentimes we do go back to the agency, and we heard one individual replying today who had trouble, apparently, getting information from the agency about the fact that he was an employee. We can only do so much. We can go to the agency and ask them. We are not an enforcement agency. We cannot force a Federal agency to hand us materials which they don't do.

Obviously, at a certain point we can move to a U.S. attorney and seek to achieve some sort of prosecution, but our U.S. attorneys are also busy individuals, and it is difficult to make that kind of case.

Mr. HORN. Other points that Ms. Balen made, which certainly are those that we have had, less paperwork for the patient, employer and physician to complete, which would speed up the entire process, make it less prone to error; and she elaborates, overall simplification of the process by reducing the length and number of forms; the authorization process, whereby a condition is accepted as work-related; and improvement in access to the claims office.

There may be States with workers' compensation systems, such as the State of Washington, just south of Alaska, which would work well and might be used as a model. Has the agency looked at some of the State systems and how they have speeded this up so the worker is not dangling out there not knowing whether they are going to be covered or not covered or the medical bills are going to be paid? What are we doing to just help the average citizen that is a Federal worker?

Mr. HALLMARK. We have looked at the information that is available for a number of State systems. There is something of a paucity of actual performance information about how the different States work. Some of that information is proprietary because the systems are private, insurance-driven systems.

We have a number of initiatives in place to do many of the things that Ms. Balen was referring to.

We have just recently moved to automated receipt and payment of pharmacy bills. That started in July 1998. We believe that will—as the IG report indicates, we believe that will significantly improve service to claimants who will no longer be required to make out-of-pocket payments because the pharmacy can readily and quickly send the bill to us electronically and receive payment directly from us.

We are likewise working on electronic billing processes for physicians and for hospitals, and we are looking at electronic transmission. We are working with the Postal Service, VA and DOD right now to ensure that we can get the electronic claim in the first place.

All of these things will not only speed up the process, they will cut down the amount of confusion with respect to submitting forms and other paper. It is understandable that a doctor in Alaska, who may not deal with OWCP that much, knows the laws and the procedures in Alaska but the OWCP Federal process is different. So we want to try to smooth that.

I would also note that where we receive the information from a doctor with regard to the medical evidence that we need, if we receive it in the form of notes or other materials, if it is the information we need, we are not going to send that back and say, no, no, it must be on this form and you must fill out box 3. We have to have the claim in the first place, but once we have the claim, we do our best to try to use the information that we can, in fact, procure.

Mr. HORN. Mr. Linehan noted in his recommendations that we just allow the Federal employees to have a basic right of Federal Court review of the workers' compensation claim and the due process? Has the administration thought of recommending that?

Mr. HALLMARK. I can't speak for the administration as a whole.

Mr. HORN. Well, let's say the administration of the agency and then move it to the administration of the Department and on up.

Mr. HALLMARK. It is OWCP's view that the FECA program is structured along the lines of the model workers' compensation programs as they were created in the early part of this century. The intent of workers' compensation was to be a no-fault nonadversarial program. The intent was to ensure that benefits could be delivered quickly to injured workers without the attendant difficulties that had been experienced in the tort system.

Now, many State systems have moved back in the direction of litigation and the kind of lawyerly process that Mr. Linehan suggested. We don't believe that's necessarily the best policy approach. The reason why OWCP delivers 96 percent of its \$2 billion benefits to the injured workers and their medical providers is because we have a straightforward, nonadversarial process.

Now, obviously, we want to make it work better; and we are anxious to make it work better.

Mr. HORN. I guess I would ask, is it really nonadversarial? It sounds like it is the clientele versus bureaucracy and it is fairly adversarial.

Forget the applause, please.

It just seems to me that the job of the agency must, overall, be fairness. You don't have to save the pot of money, and I hope that isn't the way you are judged. What you have to do is make sure that if people have an injury that is work related that they can be processed and have the benefits that the law provides. And as an administrative agency, it seems to me, if I were the head of it, I would be saying, hey, folks, there has to be a turnaround here in attitude.

It is exactly the same problem that Commissioner Rossotti faces in the Internal Revenue Service when we had long rows of witnesses from all over America before the Ways and Means Committee and Senate Finance that said, hey, we have been treated like dirt. We have a problem here. Who is going to do anything about it? Well, Congress did do something about it. They put an advisory board in.

Of course, the President hasn't submitted one name yet, and he fought us tooth and nail on doing anything to change the bureaucracy, but he signed the bill. And it could be that we need to do that to a number of agencies, maybe yours included, with an outside board that could look at and be available for complaints when people aren't served.

Now, I realize there are a lot of people that don't deserve the benefits. I had that under workers' comp. I understand that. And there's a lot of people that think the government owes them a living, and when they retire they decide to figure out some injury to get additional benefits. I know all of that, and I have been through it as an employer, as head of a university.

It was very simple. We just told our lawyers, if we are going to have this nonsense and they are fraudulent claims, let's make them know that they're in for a battle. And once you do that, usually that type of person that thinks they can get a few bucks when they aren't injured, or faking an injury, that type of person usually is going to go somewhere else and not take on the people.

But, again, that becomes an adversarial process. Sometimes it has to be, and you will let a neutral, such as a judge, decide what was right here and what was wrong. All I am saying, and I think all Congress would say is, look, if people who are Federal employees have injuries, we want to treat them fairly. And your administration here of the agency, we have got to deal fairly. And if it means firing a few Regional Directors and firing a few caseworkers, I realize that's hard with the Civil Service, but maybe the whole thing should be privatized. I don't know, but you have got to get responsiveness out of the bureaucracy.

I have found that usually, when you set the goals, the people will respond if they are fair and want to do the right thing. But there are always some in every organization, I don't know about this one, yours, anyone down the street, that people just don't get the message that the clients aren't out there just so they can have a job.

They have a job so they can help people, and that's what we need to focus on here.

I guess I would ask you this: Do you make your Federal Employees' Compensation Procedure Manual available to injured Federal workers to help assist them through the appeals process? What is the policy of the agency on that?

Mr. HALLMARK. Well, we have the Federal procedure on the Internet. It is available. We have recently updated our regulations to make them in a question-answer format to make them more usable for injured workers and their representatives as a means for pursuing their claims straightforwardly.

And I need to take a little issue with Mr. Linehan's position that there are no rights for individuals and that no one is looking over OWCP's shoulder. We have well-established and multiple avenues for appeal within the agency and outside the agency to the Employees' Compensation Appeals Board. It does provide an objective review, and as do the reconsiderations and oral hearings that are provided within the agency.

In addition to that, an individual who can show or allege that a violation of their constitutional rights has been effectuated by OWCP can take their case to the District Court, and some do. So it is not the case that we are without any oversight. In fact, we have, as I said, I believe a reasonable process.

Mr. HORN. Well, you have two appeal processes, don't you?

Mr. HALLMARK. Actually, three.

Mr. HORN. Three? Because I think there is a confusion out there as to whether these are real appeals. And maybe I'm all wrong on that, but one does the same thing the other does, and is it really an outside appeal?

Mr. HALLMARK. The three processes are first, reconsiderations, which are done within the district office. When a reconsideration is done, it is done by a claims examiner who has had no involvement in the case previously; who looks at it with fresh eyes.

I don't have the data right now, but I think that something over 35 percent of reconsiderations, possibly higher than that, result in the original decision being overturned. So we have good reason to believe there are fresh eyes being applied.

Second, the oral hearing is done by staff located here in the national office who travel to the site and do a complete review, including presentation of evidence. Something in the neighborhood of 30 plus percent of those cases are overturned and sent back for further processing because they have found that an error was made.

Third, the ECAB, likewise, is an independent organization which reviews the entire case file as it is presented, and I believe something less than 30 percent of those cases are overturned.

So the process from our perspective, appears to work. Obviously, we continually monitor it, and we look at the quality of our cases. We have an elaborate accountability review process, and one of our customer service measures is to ensure that our decisions that we are making in the first instance are correct or according to procedure. We measure that very closely, and we report that as part of our GPRA plan.

Mr. HORN. Let me continue on this appeal process. You were probably in the room when the Sheila Williams case was men-

tioned. She is Acting Director, and Mr. Chamberlin phoned and said, could you explain the appeal process to me? Now, all I can say is if it is so simple why would she have to do research to answer Mr. Chamberlin's question?

Mr. HALLMARK. Well, I can't speak to the exact circumstances, obviously, in that particular case. Every single case is different. The response that one needs to make in a given case may have to do with the particular appeal rights that were issued by the previous decider. And, in this case, it is possible that the appeal rights that were issued by the decider were incorrect.

Ms. Williams happens to be in the room here this morning, so I don't know whether she can speak, and we are governed by the Privacy Act in discussing individual case issues, so I don't want to go too far down the line of suggesting specifics.

Mr. HORN. We would be glad to have a letter and put it at this point in the record if she feels she has been misquoted, et cetera.

Mr. HALLMARK. And if I could just beg your indulgence, I would say that Ms. Williams, who is our Deputy Director for FECA and is Acting Director right now, in the regular course of her work talks with hundreds of claimants, their representatives, congressional staff and so on on a regular basis. And she is—I believe we could find many, many individuals who would tell you that she is not only gracious and helpful but that she goes out of her way on every single day to provide the kind of services that I think you would want if you were an injured worker. I think that is true of Ms. Williams, who is an extraordinary person; also true of the vast majority of our staff who are working very hard.

Mr. HORN. Well, as I remember the testimony, it wasn't that she wasn't helpful, it was that she said I'm going to have to do research on this and never got back to the individual. So we need to straighten that out with a letter.

Mr. HALLMARK. We will certainly reply for the record.

Mr. HORN. All right. Now, I guess I would ask Mr. Hallmark, the testimony regarding Regional Director Hamlett, and that has been confirmed by two witnesses, does the agency plan to have a little—I guess in China it would be Mao, putting people in the fields to get right with what they ought to be doing as opposed to what they are doing. So did that shock you, that the Director would come screaming down the hall and all that?

Mr. HALLMARK. I had been informed by Mr. Hamlett that this event occurred. He had advised me somewhat differently about the circumstances. We will certainly investigate.

Now, having heard in some detail what we heard this morning, we will certainly investigate to determine what actually happened, both in the event that occurred in the hallway and on the conference call that was also described at some length in Mr. Riordan's testimony.

Clearly, our folks try to be as courteous and sympathetic as they possibly can be. There are occasions where emotions run high. If we are discourteous in ways that are inappropriate, we need to take remedial action. Whether it is a reeducation process, as you suggest, we will have to determine.

Mr. HORN. With Ms. McGuinness' testimony there was also the testimony about District Director John Lawrence, and that has

been submitted for the record. It will be transcribed and we will send you a copy of it, and you can ask us, or please file if you think further comment is necessary on that to clarify it one way or the other from the agency's standpoint.

Mr. HALLMARK. Yes, sir.

Mr. HORN. Now let me go to what I regard as a very serious aspect, and that is the subcommittee has learned of adverse personnel actions that were initiated against Joseph Perez, a former hearing representative for the Office of Workers' Compensation Programs. We hope there has not been any negative recourse taken against Mr. Perez for his whistle-blowing activity or his testimony before the subcommittee last year. The timing of this has us concerned. Do you know anything about it?

Mr. HALLMARK. As it happens, I do. I'm part of the process that has been involved in the particular instance you talk about.

Again, under the Privacy Act I don't know that it is appropriate for me to get into specific discussions with regard to personnel actions. I certainly would be willing and eager to provide information for the record, but I certainly don't want to violate the Privacy Act in this hearing.

Mr. HORN. Well, we will be glad to insert your comments in the record at this point without objection.

I will tell you that when congressional witnesses are sanctioned by agencies when they are telling the truth, it makes us very unhappy up here; and that happiness or unhappiness only goes away when we cut about half the administration's office budget and see how they like that for a while.

But I have told one Cabinet officer if he fires that Inspector General he will be up here quite often under subpoena. Inspector Generals are there to do their duty, and they have done a great job over the last 20 years, and all I can say is I would not punish a witness before a congressional committee. That upsets people. And I don't care how they cover it up, it looks that way.

And I would just say if you have got an answer for it, great, we will file it for the record, we will take a look at it, but we don't think that's the way you treat people. We have had that problem in the Pentagon in spades over the years. So that doesn't make us too happy.

Let's see. We have about one more item, and then I think we can call it a day. Some of them we will send down to you because it will take staff work to give us an answer.

The Inspector General's report on the medical authorizations, Ms. Dalton. The subcommittee has heard many complaints from injured Federal workers, as I have noted earlier, that it takes an unreasonably long time to receive authorization for a surgery, that sometimes their immediate injury gets worse during the waiting period. Does the Office of Workers' Compensation Programs set standards to measure how quickly and efficiently it is making decisions?

Now, Ms. Friedlander, I think you are supposed to be the expert on evaluations for the Inspector General. What can you do to educate us on how do they measure their performance and do you feel the claimants are well informed through the process?

Ms. FRIEDLANDER. Mr. Chairman, it appears to us that claimants are confused at times, and we make this recommendation with the hope that if claimants get a prompt response, they at least know that the agency has heard them.

We heard today information confirming that suspicion that we have, and we think that this first step, if we tried it, and then we measure the results of that, would tell us whether we need to take any further steps or whether this is enough.

Mr. HORN. Any comments to add to that, Ms. Dalton?

Ms. DALTON. No, I think I would just concur with what Ms. Friedlander had to say. As we looked at the data we did not find serious problems. We had looked at 69 cases out of the Philadelphia region and, on average, an authorization was provided within 26 days. However, there were a number of outliers in that group.

Mr. HORN. On the survey in general, I guess I would ask, as you looked at the customer service at the Office of Workers' Compensation Programs, do you find their customer service survey a useful tool for providing information about customer service? I mean, how many questions do you need? I'm familiar with this with faculty evaluations by students, and I have found that really about one or two questions is all you need to find out what's really going on in the classroom. How about you? What's the situation here?

Ms. DALTON. We found the survey, as I said in my testimony, to be too long, too complex, and that it certainly could use significant improvements. And we made a number of suggestions to the Office of Workers' Compensation Programs on how to go about that as well as to improve the way that they are drawing their sample to get more reliable information. The way it is being done right now we did not feel it was a good measure of customer satisfaction, and certainly there is room for improvement.

Mr. HORN. Well, I would agree with you on that, and we have had submitted to us from people all over the country a lot of different surveys, and we will put an exhibit in the record on those surveys and what they show us one way or the other. So we thank you for going over that.

[The information referred to follows:]

CUSTOMER SERVICE SURVEY

1. Rate telephone responses by the OWCP ___ Good ___ Fair ___ Poor ___ ☒ Non Existent.
2. Rate Correspondence responses by the OWCP ___ Good ___ Fair ___ Poor ___ ☒ Non Existent
3. Rate Claims Examiner responses to questions asked ___ Knowledgeable ___ Informative ___ False ___ ☒ Misleading
4. Rate Claims Examiners demeanor ___ Rude ___ ☒ Unprofessional ___ Acceptable ___ Professional
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8. How long did it take to get a copy of your file ___ 1-3 months ___ 3-6 months ___ ☒ 1 year or longer ___ still trying.
9. For those who got a schedule award, was your award ___ reduced ___ delayed ___ paid as you requested and were entitled
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11. How many examinations have you been sent to ___ 1-5 ___ 5-10 ___ 10-20 ___ more, how many ___
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13. Rate reimbursement of expenses by OWCP ___ Excellent ___ Good ___ Fair ___ ☒ Poor ___ Not reimbursed yet
14. Rate your experience with OWCP nurses ___ Excellent ___ Good ___ Fair ___ ☒ Poor ___ Very Bad
15. Rate your experience with OWCP Voc. Rehab. ___ Excellent ___ Good ___ Fair ___ ☒ Poor ___ Very Bad
16. If you had Voc. Rehab. ___ Actually working ___ Comp cut for job I don't have ___ Comp Cut for more money than earning ___ Got training ___ Got a job ___ Forced to work a job I cannot do.
17. Rate OWCP Rehab Program ___ Bad experience ___ Good counselors ___ Bad counselors ___ Training satisfactory ___ Training un-satisfactory ___ no training ___ rehab ended with nothing but waste of money.
18. Rate your employers involvement in claims experience ___ Excellent ___ Good ___ Fair ___ ☒ Poor ___ Very Bad
19. Rate your employers evidence ___ False ___ in Error ___ Accurate ___ ☒ Timely ___ Relevant ___ Meant to delay or deny
20. Rate your employers timeliness in filing papers ___ Excellent ___ Good ___ Fair ___ ☒ Poor ___ Non existent.
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28. Rate the decision by the hearings representative ___ Good ___ Fair ___ ☒ Poor ___ Very Poor
29. Rate the materiel used to make the decision ___ Accurate ___ False ___ Did not address issues ___ Employer biased
30. How long did it take to get a hearing and decision ___ 1-6 months ___ 7-12 months ___ 1 to 2 years ___ longer
31. Rate OWCP reconsideration process ___ Excellent ___ Good ___ Fair ___ ☒ Poor ___ Very Poor
32. Was the decision ___ Fair ___ Unfair ___ Poorly rationalized ___ Well Rationalized
33. Do you feel that ___ You had a fair chance ___ No chance at all ___ Some chance at all ___ Never will have a chance
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35. Rate your right to find representation in appeals ___ Excellent ___ Good ___ Fair ___ ☒ Poor ___ Non existent
36. Due to your injury, the OWCP delays, did you suffer ___ Bankruptcy ___ Ruined or poor Credit ___ Divorce ___ Loss of home ___ ☒ Loss of self worth ___ ☒ Loss of dignity

I cannot sign my name because of fear Name (optional)

of reprisal from OWCP. They basically told Address (optional)

you life in their hands. You are "imprisoned."

(so to speak.) Phone No (optional)

You may check more than one box per line if you need to. Please send your filled out survey to **The Honorable Steve Horn; Chairman Subcom. On Government Management, Information, and Technology; Room B-373 Rayburn HOB; Washington, DC 20515.** Please do not send case files or requests for personal assistance with cases. Mr. Horn cannot help any individuals but those from his district with their cases. If you wish to make additional comments about the OWCP and their service, please use a clean piece of paper and keep it as short as possible.

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Name (optional)

Address (optional)

Phone No (optional)

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Mr. HORN. Mr. Hallmark, is there anything you would like to sum up on? Feel free. We will keep the record open, obviously.

Mr. HALLMARK. I wanted to speak for a moment about the medical authorization issue. We appreciate the work that the IG has done in this area. Prior to this, we had established in each Regional Director's performance agreement a requirement that they begin this year to capture data with respect to the whole range of medical authorization, following in part on the issues that were raised last summer in Long Beach.

We intend to look at that data closely and determine what areas, if any, we think need to have a performance standard and what that would look like. It is a complex issue because some things can be done very quickly, other things require a second opinion. If it is a back surgery and a complex issue, we don't want to establish a standard that would, in effect, not fit the circumstance where our most significant problems are. So that is the tack that we have taken within OWCP, and we expect to address it.

Again, I would say, in summary, that I think we are aware of the need to provide much better customer service. We have projects in place to try to do that.

One of the issues that I believe you mentioned yourself, Mr. Chairman, about the attitude of workers in this program, is something that we have been working on and are continuing to work on. As I say, this is an effort on our part to transform ourselves to become a dynamic service entity; that is, to view ourselves as service providers rather than gatekeepers. We are going to get there, and we are working very hard to do that.

There are some cases where denials occur, where disputes, oftentimes long-standing disputes, between the employee and their employing agency are intense. They get transferred to the OWCP environment when a denial occurs or information doesn't change hands, and we end up with the difficulty of trying to address those cases. It is a very hard thing for us to do.

I think our folks struggle very manfully—and womanfully—to try to accomplish it, and we are going to continue to try to make that performance better.

Mr. HORN. Very good. At this time I would like to place in the record a statement from John D. McLellan, Jr., a former Director of the FECA Program. The statement outlines his thoughts concerning the administration of FECA at the OWCP.

[The information referred to follows:]

John D. McLellan Jr.
8301 Brewster Drive
Alexandria VA 22308

Phone: 703-360-5034
Fax: 703-360-4892
Email: McLellanJ@aol.com

June 16, 1999

Hon. Stephen Horn, Chairman
Subcommittee on Government Management,
Information, and Technology
Committee on Government Reform
2157 Rayburn House Office Building
Washington DC 20515-6143

Dear Mr. Horn:

By your letter of June 1, 1999 you have asked me to submit a statement concerning the administration of the Federal Employees Compensation Act (FECA) by the Department of Labor's Office of Workers' Compensation Programs (OWCP). As was noted in the letter— as a former Director of FEC Program and subsequently an attorney assisting Federal injured workers with their attempts to get FECA benefits to which they were entitled under the FECA— your subcommittee would like to get:

1. my views on whether the FEC program is being run in a fair and efficient manner
2. my experiences in assisting injured Federal workers through the FECA process
3. findings or recommendations I may have regarding the structure of OWCP and its administration of FECA

I will start with my experience in representing FECA claimants before OWCP. This was the period from late 1987 to the end of 1995. Following my retirement from OWCP in August 1985, I decided to setup a solo practice of law in my home— partly to see if I could assist FEC claimants in getting the benefits to which they were entitled. I wanted to know if it indeed was so difficult, as I had heard many times, for an injured Federal employee to successfully get through the OWCP process to get FECA benefits. I terminated this activity at the end of calendar year 1995 totally frustrated in my efforts in dealing with the OWCP-FECA process. My letters and phone calls to determine the specific issue in a case or the specific status of cases were seldom answered. When OWCP decisions adverse to the claimant were reached and the claimant wished to go to a hearing, there was at least a one year wait to get a hearing and a decision. Appealing to the Appeals Board again was a one year plus process to a decision.

It should be understood that the cases I received were the more difficult ones generally involving occupational disease or illness. Traumatic injury cases, the large majority of FECA cases, normally are handled very well by the OWCP-FEC system— a disabled claimant has his pay continued for 45 days after which compensation kicks in. Decisions on issues are more prompt. There is little need for the claimant to get an attorney in these traumatic injury cases.

In occupational illness or disease cases, on the other hand, the claimant must prove his or her case medically before OWCP may accept the case for payment. No compensation may be paid until OWCP makes a decision accepting the claim. There is no continuation of pay as there is for traumatic injuries. It is often very difficult for a claimant to obtain the detailed reasoned medical documentation from a medical specialist to support the claim that something in the work environment to which the claimant was exposed

over a number of days caused the disability claimed. The claimant often must go without pay or compensation for months or years in such a case before a decision is issued and the hearing and appeal process successfully used.

These claimants waiting months and years to get the compensation and medical care to which they are convinced they are entitled, and who are often unable to get case status information from OWCP (during this wait), get frustrated, seek assistance from their Congress person, union, attorney, anyone who will help. And some claimants are sure that there is some conspiracy in place to intentionally deny them FECA benefits.

My experience both in administrating OWCP-FECA and assisting claimants with claims being processed through OWCP is that the system gets bogged down at the Claims Examiners level. All claims in the system go to a Claims Examiner who is to get all the necessary facts (work exposure to the alleged harmful substances, etc.) , medical documentation, etc. and then prepare a statement of accepted facts upon which to base the Claims Examiner's OWCP decision. In occupational disease cases this is a long and often difficult chore. At the same time the Claims Examiner is aware that his or her performance requirements expect that the examiner will produce decisions on a specified number of cases a week or month. Many Claims Examiners are soon aware that the caseload is larger than she or he can reasonable handle. Under this pressure many examiners will often take the easier cases first and put off "till tomorrow" the cases that are much more difficult and time consuming. The result is the system is not producing adjudications on occupational disease in a timely manner.

The most important point is it is true that there are not enough claims examiners to handle the work load. The per examiner caseload is much too high for an effective and efficient operation. The examiners handle as best they can the work load given. This load is too much. They see they can't do everything. So they take short cuts (handle the easier cases first, do occupational cases later, don't return phone calls, etc.) And everything bogs down.

I had no problem in dealing with Mr. Markey (FECA Director) and his staff. On specific case problems I might discuss the matter with Mr. Markey or his staff but for resolution the matter would be referred back to the Claims Examiner, where often the case would sit for months with no action.

My views on whether the FEC program is being run in a fair and efficient manner.

It is my opinion the OWCP officials have made and continue to make great efforts to establish and run a fair and efficient work injury compensation program. The Claims Procedure Manual and other OWCP-FEC Procedure Manuals are updated constantly and it is clear to me that the product is intended to assure basic due process and fairness in claims actions concerning the injured worker. The high quality of the written procedures shows the effort that is going into this process of making the FECA system fair and equitable.

The great and continuing computer assisted claims processing, developed by OWCP, is also noteworthy and again demonstrates OWCP management's determination to improve the FECA claims process.

While I am convinced that OWCP management has a high level of administrative skills and is exercising these to the advantage of the program, it can not be denied that the bogging down of the FECA claims at the Claims Examiner level because of the disproportionment of case load to staffing ultimately makes the process unfair to the long suffering claimants, especially those with occupational disease claims.

Findings or recommendations I have regarding the structure of OWCP and its administration of FECA

1. I do not recommend reorganizing or restructuring OWCP to improve performance. It is my experience in 30 years in the government that reorganizing an organization that is not producing as expected does not solve the problem. You have to get to the cause of the trouble. In my opinion the cause of the trouble is shortage of staff in the Claims Examiner area. Congress and the Administration would have to make some type of long term commitment to adequately staff the FECA claims operation. This has not been done in the 40+ years I have been connected with the FECA operation. If the members of Congress and the Administration do want to see Federal employees disabled due to job injuries get the timely benefits to which they are entitled by law, they will have to make such commitment.

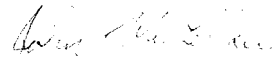
2. I do not see any evidence to indicate that there is any conspiracy within OWCP to deny claims of FECA claimants as alleged by some understandably frustrated FECA claimants.

3. The FECA hearing staff in OWCP needs to be increased to the extent necessary to be able to provide timely hearings and decisions to FECA claimants. Likewise the Employees' Compensation Appeals Board needs to have its staff increased so that appeals may be decided timely.

4. Serious consideration needs to be given to instituting a FECA appeal process to the Federal Court system as has been done for US Veterans in the Veterans' Judicial Review Act of 1988. That law provides for Federal Court review of VA benefit decisions. A similar U.S. Court review for FECA cases would eventually give more credibility to the FECA adjudication process.

I trust this provides the information you requested. You or your staff may contact me if you need more.

Sincerely,



John D. McLellan Jr.

Enclosed: 1) Background on John McLellan
2) Completed "truth in testimony" rule form

John D. McLellan Jr., J.D.
8301 Brewster Drive
Alexandria VA 22308

Phone: 703-360-5034
Fax: 703-360-4892
Email: mclellanj@aol.com

Mr. McLellan, Associate Director of the Department of Labor's Office of Workers Compensation Programs, was in charge of and directed the Federal Employees' Compensation Program from 1978 until his retirement from the federal government in 1985.

He is a 1955 graduate of the Boston University Law School and has over 40 years experience in management and adjudication systems, especially those concerning workers' compensation, both in the public and private sectors, with a notable record of accomplishing cost savings and at the same time providing better service and support to injured workers.

His service in the Federal workers' compensation programs began in 1955 when he was hired by the U.S. Department of Labor (DOL) to begin training for an executive position in the federal workers' compensation programs. He subsequently served as national director of the Longshore and Harbor Workers' Compensation Program (1962-66), Deputy Commissioner in charge of the Longshore and Harbor Workers' and Federal Employees' Compensation Programs in the New York Region (1966-78) and national director of the Federal Employees Compensation (FEC) Program, Office of Workers' Compensation Programs (OWCP), Employment Standards Administration (ESA), U.S. Department of Labor (1978-1985). In the national Longshore and FEC positions he was responsible for the written policy and procedures issued and the general administration of the programs.

From 1985-1995 he was Workers' Compensation Coordinator for G.M. Smith Associates, Inc. (GMSA) Bethesda, MD (a small national company assisting large and small employers with employee health and workers' compensation issues), and consultant on workers' compensation matters to various organizations including the Occupational Health Foundation (AFL-CIO). With Will L. Massey & Associates (Dallas, TX) he has assisted in case reviews/audits of workers' compensation cases (Longshore Act) for Alexander & Alexander's Alexis (a major third-party workers' compensation claim administrator) in Austin TX and (FECA cases) for the U.S. Postal Service in Dallas. While with GMSA he assisted the Naval Research Laboratory with its FECA cases.

Mr. McLellan served on the Technical Resources Group of the National Conference of State Legislatures, served on the Workers' Compensation Committees of the Federal, District of Columbia and American Bar Associations (ABA), and also served as the Vice-Chair of ABA's General Practice Section's Worker's Compensation Committee. In addition he is a member of the Bar of the U.S. Supreme Court and Associate member of the Virginia Bar. His extensive *pro bono* activities in his solo law practice (1986-1995) include assistance to U.S. civilian ex-prisoners of war and others seeking to obtain from the federal government the benefits to which they are entitled. Besides his

extensive knowledge of the FEC, he also is an authority on the Longshore Act, the War Claims Act, the War Hazards Act, Defense Base Act, Missing Person's Act, Hostage Relief Act and related laws.

Because of his extensive knowledge of federal disability systems he was asked to contribute a chapter on that subject to a book on disability. That book entitle **Disability Evaluations** was published the Spring of 1996 by the American Medical Association and Mosby and the editors Doctors Stephen Demeter, Gunnar Andersson and George Smith. Chapter 4 comprises Mr. McLellan's paper: *Overview of Various Disability Systems in the United States*.

Mr. McLellan is a native of New Jersey - born (1930), raised and graduated high school in Glen Ridge and then attended Drew University in Madison, New Jersey where he graduated in 1952 with a BA degree. He then went on to get his JD from Boston University Law School. He now resides in Alexandria, Virginia.

Mr. HORN. I would also like to read into the record the people that helped develop this hearing besides the Federal injured workers that we heard from from all over the country, which were very helpful.

J. Russell George, the staff director, chief counsel, who is not here right now, and that's for the Government Management, Information, and Technology Subcommittee.

On my left, your right, is the gentleman that prepared most of the work on this hearing, Matthew Ebert, an excellent senior policy adviser to the committee.

And Bonnie Heald, director of communications, is back here; and next to her is Mason Alinger, our clerk for putting this all together. Faith Weiss, minority counsel, is over here; and Earley Green, minority staff assistant.

We had two court reporters today, Julia Thomas and Pam Garland; and we had two sign language interpreters, Jan Nishimura and Earl Fleetwood.

We thank you all for your help; and, with that, this hearing is adjourned.

[Whereupon, at 12:38 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

January 26, 2000

FROM: John Victor Shepherd Sr.
230 West Delano Street
Elverta, California 95626-9215
916.991.7089 fax 916.991.7089
email jvs@inreach.com

Thank you for your January 19, 2000 acknowledgment. I do appreciate your offer of having my written testimony as part of the Congressional record. As you are aware that I could "go on for hours" on the subject of the Office of Worker's Compensation and the problems encountered, I will confine myself to the calendar years of 1999 and 2000. As this time period is a classic example of OWCP's abuse of power and their complete disregard for federal employees as well as federal laws.

BACKGROUND: I enlisted in the USAF in 1964 and became an Aircraft Electrician, discharged in 1968. I began my Civil Service career at Travis AFB in 1970, transferring to Mather AFB, Camp Pendleton and finally to McClellan AFB where employment ended in August of 1992.

In 1988, bladder cancer was discovered and surgery was performed to remove tumors, again in 1989 with more surgery and again January of 1991. On the advice of McClellan AFB Civilian Personnel, I also filed claims for compensation for Tinnitus and carpal Tunnel syndrome as well as the cancer. It was determined that my exposure to the chemical environment of aircraft maintenance might be the cause of the cancer and I was placed on worker's compensation in August of 1992 for recurrent bladder cancer.

April 1999: I received a OWCP letter, dated April 21, 1999¹, requiring a "periodic medical report from your treating physician" with the Standard Form OWCP-5c² attached. I presented it to my Urologist, who once again balked at filling out the Form OWCP-5c. The Urologist has always stated that the Form OWCP-5c, titled Work Capacity Evaluation - Musculoskeletal Conditions, was not appropriate for a urologic condition, but in the past he had filled out the Part 3 and signed it. I wrote to OWCP requesting clarification on the use of this form (Is Musculoskeletal Conditions form correct for bladder/cancer/chemical toxicity?) and after receiving no response I requested that my doctor go ahead with his report. The Urologist wrote his medical report (May 25, 1999³), very much as he had in the past, and returned it to me with a blank and unsigned Form OWCP-5c. I submitted these to OWCP!

July 1999: I received the OWCP letter, dated July 22, 1999⁴, NOTICE OF PROPOSED TERMINATION OF COMPENSATION and immediately hand-carried it to the Urologist, who, in a telephone call, stated that he did not agree with the findings of OWCP of "no longer suffering from bladder cancer", but if I needed more I should contact the Occupational Medicine Department. I hand-carried a request to Kaiser's Occupational Medicine Chief of Staff requesting that he review the OWCP findings, the urologist's report and if he felt that OWCP was in error, to write a medical narrative with the Form OWCP-5c filled out for submission to OWCP. I received his August 12, 1999⁵ letter (without the Form OWCP-5c) and forwarded it on to OWCP.

October 1999: I received the October 5, 1999⁶ letter that terminated my compensation and upon reviewing this letter and the attached supporting documents "Memo To The Director", dated July 27, 1999 and September 29, 1999. I found that I had quite a few questions concerning this termination of compensation and I wrote to OWCP, letter dated October 17, 1999⁷, requesting that my questions be reviewed and answered so that I could file an appeal with the Employees' Compensation Appeals Board (ECAB). Knowing that OWCP Claim Examiners (based on 10 years of experience) would not respond to my questions, I sent a copy of this letter on October 18, 1999⁸) to the Office of the Regional Director requesting an informal review of the findings outlined in the October 5th letter.

On October 26, 1999, I received a telephone call from a Donna F??? (I asked for the spelling of her last name and was told to just refer to her as "Donna F" as everyone did know who she was), stating that the Regional Director had given her my letter and that she had been told to get it handled. She informed me that they (OWCP) could not review my letter informally, she asked that I fax her a letter⁹ requesting reconsideration, and she would see to it that my questions were answered.

On December 1, 1999, I faxed another letter to Donna F???, requesting status of that reconsideration process, I never received a reply.

After the 1st of the year, I began calling Donna F??? at both the OWCP Regional Office and the FEC District Office, I have yet to get her last name, but she was identified as the Regional Claims Manager. I finally received a telephone call from a Miss Lee, on January 14, 2000, stating that she did in fact have my reconsideration on her desk, but she hadn't gotten to it yet!

Opinion: My family has been without OWCP compensation, medical/health benefits and life insurance since October 5th of last year, a total of 101 days (Oct 5th thru Jan 14th) and I am still waiting to have my questions answered! This "reconsideration" process is not based on any new medical evidence, but solely on points of federal law.

- ▶ *Did two OWCP Claims Examiners over-step their authority and make medical decisions?*
The July 27, 1999¹⁰ MEMO TO THE DIRECTOR (dated five days after the July 22, 1999 letter) states that "latest and most recent report indicates Mr. Shepherd does not show any tumor growth and is free of bladder cancer." Reading the May 25th medical report is does state that I do not show any tumor growth, but the cancer free statement just isn't there. The September 29, 1999¹¹ MEMO TO THE DIRECTOR contains a hand-written statement signed by a Senior Claims Examiner stating that "No evidence that these conditions disable from the performance of his normal job duties", is this Senior Claims Examiner qualified to make a medical statement such as this?
It is apparent that this Senior Claims Examiner has never read the job description for an WG-2892-10 Aircraft Electrician¹². Nor were the claims A13-1081960 or A13-0998242 ever reviewed, if they were it would be noted that any of the three "conditions" prevent me from ever returning to my former job.

Tinnitus/hearing loss - medically restricted from any noise environment
Carpal Tunnel - medically restricted from lifting and repetitive hand motions
Cancer - medically restricted from chemical environments

- ▶ *Did OWCP disregard The Code of Federal Regulations in this termination order?*
CFR Title 5, Volume 1 Part 353 Section 353.101 Scope¹³ describes who is covered under this section.
CFR Title 5, Volume 1 Part 353, Section 353.102 Definitions¹⁴ states that "Fully recovered means compensation payments have been terminated on the basis that the employee is able to perform all of the duties of the position he or she left or an equivalent one" this means no medical restrictions! Section 353.102 (2) (ii) states " There is a medical reason to restrict the individual from some or all essential duties because of possible incapacitation (for example, a seizure) or because of risk of health impairments (such as further exposure to a toxic substance for an individual who has already shown the effects of such exposure)."

Conclusion: I do firmly believe that this illegal termination of compensation is based on only one factor! The mandate from Employment Standards Administration as outlined in their FY2000 Annual Performance Plan¹⁵ and the Office of Worker's Compensation Programs Strategic Plan¹⁶.

I thank you for your time and for your assistance in having it posted as part of the record of the Government Management, Information and Technology Subcommittee.

Sincerely,


John J. Shepherd Sr.

U.S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS
PO BOX 19457
SAN FRANCISCO CA 94119
Phone: (415) 975-4090

April 21, 1999

File Number: 95626-13-0914270
Date of Injury: 07/25/1988
Employee: John Shepherd

John V. Shepherd
230 W Delano Street
Elverta, CA 95626

Dear Mr. Shepherd:

The Office of Workers' Compensation Programs requires periodic medical reports from your treating physician regardless of the severity of your condition, length of time you have been receiving benefits, or your age. These periodic reports are necessary even if your condition is such that no improvement seems likely or possible.

Please have your physician submit the following information in a detailed narrative report within 60 days:

1. A description of the current objective findings and diagnoses.
2. An opinion, with medical reasons for the opinion, regarding causal relationship of your condition to the accepted work injury or disease.
3. A completed Work Restriction Evaluation Form and an indication when you will be able to return to work or participate in vocational rehabilitation.

IMPORTANT: Present this letter to your physician so that he/she is made aware of the required detailed narrative report to be included with the completed Work Restriction Evaluation Form. The physician may submit an itemized bill on Form HCFA-1500 with the report.

Sincerely,

RON KOSTER
Claims Examiner

Enclosure: Work Restriction Evaluation Form, OWCP

The Permanente Medical Group, Inc.
 2025 MORSE AVENUE
 SACRAMENTO, CALIFORNIA 95825-2115
 (916) 973-5000

JACK E. ROZANCE, M.D.
 Physician-in-Chief

DAVID A. HERBERT, M.D.
 Assistant Physician-in-Chief

DEBORAH W. ROYER
 Medical Group Administrator

M.B. O'NEIL, JR., M.D.
 Assistant Physician-in-Chief

ANTIOCH	RANCHO CORDOVA
DAVIS	REDWOOD CITY
FAIRFIELD	RICHMOND
FREMONT	ROSEVILLE
FRESNO	SACRAMENTO
GILROY	SAN FRANCISCO
HAYWARD	SAN JOSE
MARTINEZ	SAN RAFAEL
MILPITAS	SANTA CLARA
MOUNTAIN VIEW	SANTA ROSA
NAPA	S. SACRAMENTO
NOVATO	S. SAN FRANCISCO
OAKLAND	STOCKTON
PARK SHADELANDS	VACAVILLE
PETALUMA	VALLEJO
PLEASANTON	WALNUT CREEK

DENNIS L. OSTREM, M.D.
 Assistant Physician-in-Chief

May 25, 1999

John V. Sheperd, Sr
 230 West Delano Street
 Elverta, California 95626

MR# 05165865

TO WHOM IT MAY CONCERN:


This is to certify that I saw Mr. John Victor Sheperd the Senior last week for a routine cystoscopy to follow up on the status of his bladder cancer. Mr. Sheperd had his first bladder tumor in August of 1988, followed by recurrences in June of 1989, and again in January of 1991. Cystoscopy since then have revealed no evidence of recurrent tumor growth.

His most recent cystoscopy again revealed no clinical recurrences.

Mr. Sheperd is scheduled for continued surveillance cystoscopy on an annual basis.

If there are any further questions regarding Mr. Sheperd's urologic status, please feel free to call or write.

Sincerely,


DEEPAK CHABRA, M.D.
 Department of Urology

cc: Dr. Chabra
 DC/lr



U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS
PO BOX 193769
SAN FRANCISCO CA 94119
Phone: (415) 975-4090

July 22, 1999

File Number: 95626-13-0914270
Date of Injury: 07/25/1988
Employee: John Shepherd

John V. Shepherd
230 W Delano Street
Elverta, CA 95626

Dear Mr. Shepherd:

NOTICE OF PROPOSED TERMINATION OF COMPENSATION


This is to advise you that we propose to terminate your compensation for wage loss on account of the injury identified above for the following reason:

You are no longer suffering from bladder cancer.

The medical reports on which this decision is based are enclosed. If you disagree with the proposed action, you may submit additional evidence or argument relevant to the issue described in the preceding paragraph. Such evidence or argument must be submitted to this Office within thirty days of the date of this letter. Your compensation will not be terminated during this thirty-day period. If no response is received within thirty days, we shall proceed with the termination of your compensation.

Under Office of Personnel Management Regulations, an employee who recovers from a compensable injury within one year is entitled to mandatory job restoration, and is expected to apply for reemployment within 30 days of the cessation of compensation. Further information concerning restoration rights may be obtained from your agency or any OPM area office. You may also wish to contact your former employing agency or OPM for advice on continuing any health insurance and/or life insurance coverage.

Sincerely,


Barbara Kennedy
Senior Claims Examiner

DEPARTMENT OF THE AIR FORCE
SACRAMENTO AIR LOGISTICS CNTR
77 SPTG-DPCEB
3411 OLSON STREET SUITE 2
MCCLLELLAN AFB, CA 95652

MEMO TO THE DIRECTOR

Case Number: 130914270
 Claimant Name: John Shepherd

Date: 07/27/1999

ISSUE:

The issue is whether Mr. Shepherd's occupational disease continues, thus entitling Mr. Shepherd to further compensation for wage lost.

REQUIREMENTS OF ENTITLEMENT:

For Mr. Shepherd to be entitled to continuing compensation payments, the medical evidence must establish that Mr. Shepherd continues to be disabled due to his occupational disease (bladder cancer).

BACKGROUND:

The department of the Air Force, McClellan Air Force Base, California employed Mr. Shepherd as an aircraft electrical systems installer/repairer. While performing duties associated with the position of aircraft electrical systems installer/repairer Mr. Shepherd came in contact with a number of known carcinogens. Ultimately, in 1988, Mr. Shepherd was diagnosed with bladder cancer. Mr. Shepherd filed timely notice with this Office and bladder cancer was accepted as an occupational disease. Mr. Shepherd had surgery to remove tumors in 1988 and again in 1989 and 1991 when tumors returned. Mr. Shepherd worked intermittently during this period until 08/04/1992 when Mr. Shepherd began receiving regularly scheduled compensation payments. Mr. Shepherd continues to receive compensation payment through the present time.

DISCUSSION OF EVIDENCE:

Mr. Shepherd's most recent medical report, submitted by Dr. Deepak Chabra, Department of Urology, Kaiser Permanente, Sacramento, CA, states that Mr. Shepherd shows no evidence of recurrent tumor growth, and has not since his last surgery in 1991.

BASIS FOR DECISION:

The latest and most recent report indicates that Mr. Shepherd does not show any tumor growth and is free of bladder cancer.

CONCLUSION:

It is recommended that compensation be terminated because Mr. Shepherd is no longer suffering from bladder cancer, Mr. Shepherd's accepted occupational disease.

Ron Koster
 Claims Examiner

The Permanente Medical Group, Inc.

8025 MORSE AVENUE
SACRAMENTO, CALIFORNIA 95825-2115
(916) 973-5000

JACK E. ROZANCE, M.D.
Physician-in-Chief

DAVID A. HERBERT, M.D.
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Assistant Physician-in-Chief

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PARIS SHADELANDS
PETALUMA
PLEASANTON
RANCHO CORDOVA
REDWOOD CITY
RICHMOND
ROSEVILLE
SACRAMENTO
SAN FRANCISCO
SAN JOSE
SAN RAFAEL
SANTA CLARA
SANTA ROSA
S. SACRAMENTO
S. SAN FRANCISCO
STOCKTON
VACAVILLE
VALLEJO
WALNUT CREEK

August 12, 1999

U.S. Department of Labor
Employee Standards Administration
Office of Workers Compensation Programs
P.O. Box 19457
San Francisco, CA 94119
ATTN.: Ron Koster, Claims Examiner

RE: SHEPHERD, JOHN
MR#: 516 58 65
OWCP#: 95626-13-0914270
DOI: 07/25/88

Dear Mr. Koster:

I am in receipt of your letter to Mr. Shepherd dated April 21, 1999, wherein you asked for an update of the patient's current medical problems.

As you have received a report from Dr. Chabra on May 25, 1999, where there is no sign of any clinical recurrence of his bladder cancer, there was a response from Barbara Kennedy, Senior Claims Examiner in your office on July 22, 1999 that compensation be terminated because he was no longer suffering from bladder cancer. Therefore, your letter, as well as Ms. Kennedy's letter, were both forwarded to me for clarification.

I had seen Mr. Shepherd in the early 1990's, and had given him a permanent restriction as of June 4, 1991 from any significant exposure to Turko JP-4 or other paraffin-containing solvents, as these chemicals have been noted to be carcinogenic to the bladder. Even though he has not had a recurrence of his bladder cancer, one would not discontinue this restriction, much like one would not encourage a patient recovering from lung cancer to restart his smoking. The fact that Mr. Shepherd is not suffering from bladder cancer at this time is a reflection of probably the modifications of the various multifactorial risk factors for bladder cancer, one of which would be exposure to the solvents named above.



RE: SHEPHERD, JOHN

Page -2-

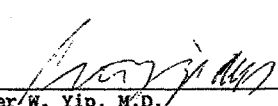
August 12, 1999

With regard to his tinnitus, the patient's restrictions are that he should not exceed the general acceptable maximum noise level as established by OSHA standards.

Finally, with regards to his carpal tunnel syndrome, Dr. Powers had restricted Mr. Shepherd's repetitive hand motions to an occasional basis for an indefinite period of time as well.

I am not aware of any change in any of the restrictions, especially the first one regarding his exposure to the paraffin and other solvents noted above.

I hope this report helps you in your evaluation of Mr. Shepherd's case. Should you have any further questions, please do not hesitate to contact me.



Peter W. Yip, M.D.
Occupational Medicine

PWY:pmt870/#D1376/sac

cc: Occ Med Shadow File
Peter Yip, M.D.
Clinic Chart (Roseville)
John Shepherd (230 West Delano Street, Elverta, CA 9526-9215)

MEMO TO THE DIRECTOR

RE: JOHN SHEPHERD

FILE # 13-0914270

09/29/1999

ISSUE:

Whether to finalize termination of Workers' Compensation benefits to Mr. Shepherd.

BACKGROUND:

On 07/22/1999 a Noticed of Proposed Termination was sent to Mr. Shepherd indicating this Office was proposing to terminate Workers' Compensation Benefits because Mr. Shepherd was no longer suffering from bladder cancer.

In response to this notice Mr. Shepherd contacted Kaiser Permanente to have additional medical evidence submitted to this Office for consideration. Dr. Peter Yip submitted a letter dated, 08/12/1999, discussing Mr. Shepherd's condition(s).

DISCUSSION:

Dr. Yip's letter addressed not only Mr. Shepherd's claim for bladder cancer (File # 13-0914270), but also for Mr. Shepherd's claims with this Office for tinnitus (File # 13-1081960) and carpal tunnel syndrome (File # 13-0998242).

Mr. Shepherd has been free of bladder cancer since the removal of tumors in 1991. Dr. Deepak Chhabra in a report, dated 05/25/1999 indicates Mr. Shepherd remains cancer-free. Dr. Yip acknowledged Dr. Chhabra's report. However Dr. Yip noted he had placed Mr. Shepherd on "permanent restriction" from any significant exposure to certain chemical solvents noted to be carcinogenic to the bladder. Dr. Yip noted that these restrictions should remain in effect to prevent the possible recurrence of Mr. Shepherd's bladder cancer.

Dr. Yip's point is noted. However, in regard to terminating Mr. Shepherd's benefits, the issue is whether or not Mr. Shepherd is suffering from bladder cancer, and not if it will recur. In addition, the Employees' Compensation Appeal Board has held that fear of a new injury or recurrence is not the basis for the payment of compensation. Patricia A. Keller, 45ECAB ___, (Docket No. 93-1091, issued on December 30, 1993)

Mr. Shepherd's case file for tinnitus (File # 13-1081960) is a separate condition and is not related to the issue at hand. It should also be noted that the claim for tinnitus is currently listed as being in C-5 status. Mr. Shepherd's case file for carpal tunnel (File # 13-0998242) is likewise a separated condition and is also currently listed as being in C-5 status. If Mr. Shepherd feels he has any residuals and/or recurrence of these conditions and wishes to pursue either claim, it would be a separate action. Since these cases are not at issue in this action, no further discussion is needed.

CONCLUSION:

It is established that Mr. Shepherd is no longer suffering from bladder cancer.

ECAB findings state that fear of recurrence is not the basis for payment of compensation.

The claims for tinnitus and carpal tunnel are separate from the claim for bladder cancer and are not relevant in determining whether or not Mr. Shepherd continues to have bladder cancer.

RECOMMENDATION:

Terminate Mr. Shepherd's compensation for wage loss as proposed.

Ron Koster
Claims Examiner

No evidence that the condition described in the recommendation of his normal job duties

Cancer

10/1/99

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS
PO BOX 193769
SAN FRANCISCO CA 94119
Phone: (415) 975-4090

October 5, 1999

File Number: 95626-13-0914270
Date of Injury: 07/25/1988
Employee: John Shepherd

John V. Shepherd
230 W Delano Street
Elverta, CA 95626

Dear Mr. Shepherd:

Your claim for compensation benefits has been disallowed for the reason stated in the enclosed copy of the Compensation Order. The decision was based on all the evidence of record, and on the assumption that all available evidence has been submitted. If you disagree with the decision, you may follow any one of the courses of action outlined on the attachment of this letter.

Under Office of Personnel Management regulations, an employee who recovers from a compensable injury within one year is entitled to mandatory job restoration, and is expected to apply for reemployment with the employing Federal agency immediately upon recovery. Employees who take longer than one year to recover are entitled to priority consideration, provided they apply for reemployment within thirty days of the cessation of compensation. Further information concerning restoration rights may be obtained from your agency or any OPM area office. You should also contact your former employing agency or OPM for advice on continuing any health insurance and/or life insurance coverage.

IN ALL DISABILITY CASES, FURTHER MEDICAL TREATMENT IS NOT AUTHORIZED AND PRIOR AUTHORIZATION, IF ANY, IS HEREBY TERMINATED.

Sincerely,



Ron Koster
Claims Examiner

DEPARTMENT OF THE AIR FORCE
SACRAMENTO AIR LOGISTICS CNTR
OO-ALC-DPCE
6053 ELM LANE
HILL AFB, UT 84056

Enclosure: Compensation Order w/appeal rights
Memorandum to the Director

U. S. DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMPENSATION PROGRAMS

.....
In the matter of the claim for compensation
Under the Federal Employees' Compensation
Act (5 U.S.C. 8101 et seq.) of

JOHN V. SHEPHERD
Claimant

COMPENSATION ORDER

REJECTION OF CLAIM

CASE FILE NO. 130914270

Employed by: Department of the Air Force
McClellan Air Force Base, CA 95652

.....
Such investigation in respect to the above-entitled claim having been made as is considered necessary, and after due consideration of such claim and reports of record, the Office makes the following:

FINDINGS OF FACT

1. Timely notice of injury and claim for compensation were respectively given and filed by the Claimant, a Federal employee, for an injury of bladder cancer sustained in the performance of duty.
2. The claim was approved for bladder cancer
3. The Memoranda to the Director dated 07/27/1999 and 09/29/1999 are made a part hereof by reference.
4. The evidence of file establishes that the claimant is no longer disabled for work due to the effects of the accepted injury/condition.

Upon the foregoing findings of fact, it is ORDERED that entitlement to continuing compensation for wage loss be, and the same hereby is, TERMINATED effective 10/10/1999 for the reason that Mr. Shepherd no longer has bladder cancer.

Given under my hand at
San Francisco, California,
this fourth day of October,
for the Director of Workers'
Compensation Programs.

By: Barbara Kennedy
Senior Claims Examiner

October 17, 1999

TO: Office of Worker's Compensation
Post Office Box 193769
San Francisco, California 94119

ATTN: Mr. Ron Koster, Claims Examiner

FROM: John Victor Shepherd Sr.
230 West Delano Street
Elverta, California 95626-9215
(916) 991-9309 fax (916) 991-7089
email jvs@inreach.com

RE: October 5, 1999 letter of termination

Dear Mr. Koster,

I am addressing this letter to you as the signor of the October 5th letter. I have questions regarding this October 5, 1999 action that I would appreciate having answered before deciding as to whether to appeal this action with ECAB.

It has always been my understanding that medical personnel (attending physician - August 17, 1992) would make the determination as to when I could return to work. I have read both Dr. Chabra's and Dr. Yip's reports and find no mention of returning to the position of WG-2892-10 Aircraft Electrician. In fact Dr. Yip does state that my medical restrictions are exactly the same as they were in 1992 when I was first placed on compensation.

Dr. Jacqueline R. Jayne, M.D. McClellan AFB, Dr. Alton G. Wills, M.D., McClellan AFB, Dr. Clyde M. Gaffney M.D. OWCP 2nd Opinion, all concurred with both Dr. Chabra and Dr. Yip that the risk of occupational / environment exposure to chemicals was the cause of the bladder cancer and that continued exposure to these chemicals would be a 50 to 70 percent likelihood of recurrence.

Question:

Was I not originally placed on compensation in August of 1992 for the "recurrence" of bladder cancer with the OPM Standard Form 2824D stating that NO accommodations were available at McClellan AFB?

Who was or is the Medical Doctor that reviewed this September 29, 1999 decision and made the determination that I can return to a toxic environment?

On the subject of "return to work": I have searched the internet, the USC, the code of Federal Regulations, the FECA for a definition of "return to work" and the only reference found is under Restoration Rights and states; *"When compensation is terminated on the basis of medical evidence that the employee no longer has residual limitations from the injury and can return to the former job without limitations"* (OPM pamphlet dated July 31, 1998). In the Memo to the Director dated September 29, 1999 you refer to "permanent restrictions". In short, these medical restrictions prohibit exposure to any paraffin-containing chemicals!

Question:

How can OWCP determine that I can return to the duties of a WG-2892-10 Aircraft Electrician and stay within these medical restrictions?

What is the official OWCP definition of "return to work"?

Does CFR Title 5, Chapter 1 Subpart A, Section 353.102 apply?

Physically disqualified means that:

(1)(i) For medical reasons the employee is unable to perform the duties of the position formerly held or an

equivalent one, or (ii) There is a medical reason to restrict the individual from some or all essential duties because of possible incapacitation (for example, a seizure) or because of risk of health impairment (such as further exposure to a toxic substance for an individual who has already shown the effects of such exposure).

(2) The condition is considered permanent with little likelihood for improvement or recovery.

A WG-2892-10 Aircraft Electrician position description (OPM web site dated October 19, 1998) requires the following for performance of normal job duties:

Factor 3. Physical Effort

Employee frequently climbs up and down ladders, check stands, work platforms, scaffolding, and aircraft structures while making repairs or installations. The work requires long periods of standing and considerable kneeling, bending, stooping, and stretching. The work frequently requires individuals to make repairs or installations in hard-to-reach places requiring awkward and strained positions. In addition, the work requires lifting and carrying aircraft electrical items weighing up to 20 pounds unassisted and occasionally up to 50 pounds with assistance of lifting devices or other workers.

Factor 4. Working Conditions

Employee works in hangars and on flight lines. Workers are subject to drafts, noise, and varying temperatures in hangars and weather, temperature, and noise extremes on flight lines. Workers are exposed to dust, dirt, grease, oil, fumes, solvents and other aircraft fluids while working on aircraft in various stages of repair or modification. Workers at this level are exposed to the possibility of abrasions, cuts, burns, electrical shock, skin and eye irritation, and falls from elevated work areas e.g., check stands and aircraft structures. In addition, some workers on flight lines are exposed to potential injury from turning rotors or jet blast during engines run ups.

The hand-written statement on the September 29, 1999 Memo to the Director states "*No evidence that these conditions disable from the performance of his normal job duties*". Yet each of these conditions have in effect medical restrictions that do prevent me from carrying out the normal job requirements for a WG-2892-10 Aircraft Electrician. Case # 13-0998242 - Carpal Tunnel - December 1, 1992, Dr. William Powers placed medical restrictions of occasional repetitive hand motion and no lifting or carrying over 10 pounds. Case # 13-1081960 - High-frequency hearing loss, tinnitus, vertigo - September 11, 1995, Dr. William Johnson, OWCP 2nd Opinion, placed medical restrictions of avoidance of all forms of noise as well as the 1991 medical restrictions of the permanent restrictions from paraffin-containing chemicals!

In 1995, I was placed in the OWCP Vocational Rehabilitation Program and the outcome of this was the September 18, 1996 termination of the vocational rehabilitation effort due to "*not able to benefit from vocational rehabilitation services. The rationale for this counselor's decisions is based on the fact that Mr. Shepherd does have multiple injuries and the restrictions placed on him by each of these injuries would indicate that Mr. Shepherd is not able to return to employment*".

I have contacted the "employing Federal agency" as directed by your October 5, 1999 cover letter. McClellan AFB is undergoing base closure and referred me to Hill AFB. Neither Federal agency has any use for a WG-2892-10 Aircraft Electrician on medical restrictions!

October 18, 1999

TO: Ms. Donna H. Onodera, Regional Director
71 Stevenson Street, Suite 1705
San Francisco, California 94105

FROM: John Victor Shepherd Sr.
230 West Delano Street
Elverta, California 95626-9215
(916) 991-9309 fax (916) 991-7089
email jvs@inreach.com

RE: Termination of Worker's Compensation - A13- 0914270

Dear Ms. Onodera,

As you can see from the enclosed documents my compensation has been terminated with OWCP.

I am requesting a informal review by someone above the Central Valley Team Section to insure that this action is correct.

It has always been my understanding that benefits could not be terminated as long as I was medical restricted from returning to my former position or the completion of vocational rehabilitation into another career field.

I thank you for your time and you assistance.

Sincerely,

John V. Shepherd Sr.

October 26, 1999

TO: Ms. Donna H. Onodera, Regional Director
71 Stevenson Street, Suite 1705
San Francisco, California 94105

ATTN: Donna "F" 1-415-975-4257

FROM: John Victor Shepherd Sr.
230 West Delano Street
Elverta, California 95626-9215
(916) 991-9309 fax (916) 991-7089
email jvs@inreach.com

RE: Termination of Worker's Compensation - A13- 0914270
Request for Reconsideration

Dear Ms. Onodera,

As per your (Donna "F") October 26th telephone conversation, I am requesting reconsideration of the October 5, 1999 decision (termination of compensation). Please refer to my October 17, 1999 letter as to why I feel this termination was incorrect.

Again I thank you for your time.

Sincerely,

John V. Shepherd Sr.

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